maryland
health services
cost review commission

611th Meeting of the Health Services Cost Review Commission
September 13, 2023

(The Commission will begin in public session at 11:00 am for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00pm)

CLOSED SESSION
11:30 am

1. Discussion on Planning for Model Progression - Authority General Provisions Article, §3-103 and §3-104
2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on July 12, 2023
2. Docket Status – Cases Closed
3. Docket Status – Cases Open

   2626R Encompass Health Rehabilitation Hospital of Southern Maryland
4. Final Recommendation on Proposed Financial Assistance and Medical Debt Collection Regulations, COMAR 10.37.10.26
5. Policy Update and Discussion
   a. Model Monitoring
   b. ED Wait Times Update
6. Revenue for Reform Implementation Plan
7. Hearing and Meeting Schedule

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AMENDED
MINUTES OF THE
610th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
July 12, 2023

Chairman Adam Kane called the public meeting to order at 11:03 a.m. In addition to Chairman Kane, in attendance were Commissioners Joseph Antos, PhD, Ricardo Johnson, Maulik Joshi, Nicki McCann, and Dr. Josh Sharfstein. Commissioner Elliott participated virtually. Upon motion made by Commissioner Joshi and seconded by Commissioner Antos, the meeting was moved to Closed Session. Chairman Kane reconvened the public meeting at 1:12 p.m.

COMMISSIONERS UPDATE

Chairman Kane welcomed Nicki McCann, Johns Hopkins Health System and Dr. Josh Sharfstein, Vice Dean of the Johns Hopkins' Bloomberg School of Public Health as new Commissioners.

STAFF UPDATE

Ms. Katie Wunderlich, Executive Director, introduced Ms. Daniela Tamayo. Ms. Tamayo will be working in Hospital Rate Regulation as a Rate Analyst.

REPORT OF JULY 12, 2023, CLOSED SESSION

Mr. Dennis Phelps, Deputy Director, Audit & Compliance, summarized the minutes of the July 12, 2023, Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM THE JUNE 14 , 2023, PUBLIC MEETING, AND CLOSED SESSION

The Commission voted unanimously to approve the minutes of the June 14, 2023, Public Meeting and Closed Session.

ITEM II
CLOSED CASES

2625A- Johns Hopkins Medical System

ITEM III
OPEN CASES

2622N MedStar St. Mary's Hospital

On April 6, 2023, MedStar St. Mary's Hospital ("MSMH" or "the Hospital"), submitted a partial rate application requesting the creation of a new rate for Occupational Therapy (OT) services. The Hospital also requested an effective date of July 1, 2023, for OT services.

HSCRC policy is to set the rates for new services at the lower of the statewide median or at a rate based on a hospital's projections. Based on the information received, the Hospital requested an OT rate of $16.76. The statewide median rate is $16.79.

Staff recommend the following:

1. That a rate of $16.76 be approved effective July 1, 2023, for OT services;
2. That the OT rate center is not rate realigned until a full year of cost data has been reported to the Commission; and
3. That no change be made to the Hospital's Global Budget Revenue for the OT services.

Commissioners voted unanimously in favor of Staff's recommendation.

ITEM IV
CONFIDENTIAL DATA REQUEST BY UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE DEPARTMENT OF ANESTHESIOLOGY

Ms. Claudine Williams, Principal Deputy Director, Data Management, and Integrity presented staff's recommendation on granting the release of HSCRC confidential patient level data to The University of Maryland School of Medicine (UMSOM), Department of Anesthesiology (see "Final Staff Recommendation for a Request to Access HSCRC Confidential Patient Level Data from The University of Maryland School of Medicine Department of Anesthesiology" available on the HSCRC website).

UMSOM Department of Anesthesiology is requesting access to the HSCRC Confidential Inpatient and

Outpatient Hospital Data ("the Data") to evaluate the clinical and financial outcomes associated with the implementation of a statewide Critical Care Coordination Center.

Researchers aim to objectively study:

1. Efforts to address healthcare disparities throughout the State of Maryland specially for areas under-served;
2. Use of a public, safety-based, EMS agency/model to provide administrative control and direction for provision of critical care services under pandemic and non-pandemic conditions;
3. The importance of having a state-level intensive care physician who can provide medical direction for patients who are unable to be transferred from an emergency department (ED);
4. The effect of a Critical Care Coordination Center on ED crowding; and
5. How critical care, like trauma and cardiac/stroke cases, can be regionalized at a state level.

Project Investigators received approval from the Maryland Department of Health Institutional Review Board (IRB) on September 29, 2022, and the MDH Strategic Data Initiative office on October 28, 2022. The Data will not be used to identify individual hospitals or patients. The Data will be retained by UMSOM until June 14, 2024. At that time, the Data will be destroyed, and a Certification of Destruction will be submitted to the HSCRC.

Staff's recommendation is as follows:

- HSCRC staff recommend that the request by UMSOM for the Data for Calendar Year 2020 through 2023 be approved.
- This access will include limited confidential information for subjects meeting the criteria for the research.

Commissioners voted unanimously in favor of Staff's recommendation.

ITEM V
FINAL RECOMMENDATION ON UPDATES TO EFFICIENCY POLICIES

Mr. Allan Pack, Principal Deputy Director, Population-Based Methodologies, presented Staff's final recommendation to update the HSCRC Efficiency Policies (see" Final Recommendation on Modification to Efficiency Policies: Full Rate Application, Integrated Efficiency Methodology, and Capital Financing" available on the HSCRC website).

The HSCRC currently uses three related policies to assess hospital efficiency:

- Integrated Efficiency Policy (IEP): Used to identify and address relative efficiency performance to bring hospitals closer to peer average standards over time through scaled inflation.
- Full Rate Review Methodology: Establishes a clear standard so that the Commission may reset a hospital's rate structure to align with its current services.
- Capital Financing Policy: Used to provide hospitals with predictable rate updates for major capital projects**.**

The three Efficiency Policies include three major components – Volume-Adjusted Inter-Hospital Cost Comparison (ICC), Medicare Total Cost of Care (TCOC) Benchmarks, and Commercial TCOC Benchmarks.

Staff received 10 comment letters containing a broad array of topics that covered the following thematic areas: 1) Philosophical Concerns; 2) Responses to Staff Recommendations; and 3) Technical Considerations.

Defining Efficiency in the Model

Both CareFirst and MHA expressed concern about the underlying efficiency evaluation for different reasons:

- CareFirst stated that greater clarity of the individual cost categories making up a hospital's structure could create an opportunity to base the efficiency policy on the relative percentages that the cost categories make up of each hospital's budget. This would require enhancements to the annual filing. The concern is that under the current ICC, a hospital with 15% overhead and a hospital with 30% overhead could score similarly in the cost per case calculation.

- MHA stated that stakeholders should determine if using equivalent case mix adjusted discharges to calculate permanent revenue in the Interhospital Cost Comparison is appropriate in a population-based payment system.

Staff Response:

Staff appreciate stakeholders' concern that the ICC does not identify individual excess cost categories, as is done with a Medical Loss Ratio (MLR) approach but notes that MLR works more readily in the insurance market because non-overhead expenses, i.e., medical claims, are deemed reasonable. Given that state law requires that the Commission ensures that all costs are reasonable, however, this method may not work as well for hospital efficiency analyses.

Staff are particularly concerned about the ICC in a population-based system, but until the stakeholders and Commissioners agree to pursue changes to Maryland statute, staff cannot advance a policy that fails to assess that: (1) The total costs of all hospital services offered by or through a facility are reasonable; (2) The aggregate rates of the facility are related reasonably to the aggregate costs of the facility.

Overlapping TCOC Risk

Several commenters expressed concern about the overlapping TCOC risk in the Efficiency policies:

- MHA noted in a long-term workgroup, stakeholders should address overlap of TCOC risk among HSCRC payment policies.
- Adventist is concerned that the proposed ICC policy cannot be properly evaluated without consideration of the to-be-determined deregulation adjustments and the CTI payment policy since all three policies have a significant impact on hospitals in RY24.
- CareFirst, Johns Hopkins, and Mercy Hospital noted that they understood and appreciated why Staff are balancing the cost per case metric with TCOC performance metrics.

Staff Response:

Staff sympathize with Adventist's concern about additional revenue adjustments resulting from non-efficiency policies, especially ones that evaluate TCOC; however, the Commissioners have made clear their desire for such a policy. It was necessary that Staff had a Full Rate Application approach in place when the Full Rate Application moratorium expired on June 30th.

Moreover, controlling TCOC is essential for the waiver to succeed. TCOC evaluation in the Commission's efficiency policies is essential.

Staff appreciate CareFirst's, Johns Hopkins', and Mercy's recognition that the Commission must balance both evaluations of efficiency in its Full Rate and Integrated Efficiency policies.

Outliers

Two commenters opined on efficiency "outliers" and how to address them:

- LifeBridge noted that given the design of the Interhospital Cost Comparison (ICC), there was the likelihood of a hospital becoming "stuck".... [and] The latest ICC modeling continues to suggest that even with the $13.2 million of already removed permanent revenue and the potential of

another $22.5 million for fiscal year 24, a substantial revenue reduction would still be required for Sinai to not be deemed as a 4th quartile inefficient performer.

- Johns Hopkins stated that the HSCRC efficiency policies have been used to identify outliers in the system and to provide a way for those outliers to be brought back towards the statewide average via rate actions. JHHS believes that the current proposal of utilizing the quartile ranking continues to support this concept, which we believe is appropriate.

Staff Response:

Staff appreciate Johns Hopkins comment that HSCRC efficiency policies have historically been used to bring "outliers" in line with the statewide average and noted that an expansion of the current quartile ranking approach, e.g., the bottom half, would expand the definition of outliers from typical historical practice.

Staff recognize LifeBridge's concern about the potential magnitude of the policy if it is utilized in subsequent years; however, staff noted that multiple policy elements have been introduced to mitigate this concern including revisions to TCOC scoring and the opportunity for Revenue for Reform buy outs. Stakeholders are welcome to suggest additional enhancements for future policy updates.

Disproportionate Impact

University of Maryland Medical System has expressed concern about the disproportionate negative impact that current policies have on rural and safety net hospitals. To that end, UMMS is requesting that the Commission complete another evaluation of the disproportionate share hospital (DSH) adjustment as well as other components of the methodology such as the resident cap.

MHA and LifeBridge have similarly expressed a desire to explore alternatives to the DSH adjustment and to re-evaluate the peer group comparisons, which previously were used to address higher costs related to socioeconomic disadvantaged patients.

Staff Response:

- Promoting health equity for all Marylanders, especially in underserved communities, is a core accommodation made to support health equity. Staff have evaluated the Efficiency policies and conclude the following:
- Staff have repeatedly shown there is no statistically significant relationship between measures of socioeconomic disadvantage (poor share, ADI, dual eligibles, etc.) and ICC performance.

- Of the 43 hospitals evaluated, only 3 are rural and are negatively affected by the proposed Integrated Efficiency policy, while 4 rural hospitals are eligible for rate enhancements under the Full Rate Application policy.
- Additionally, the inclusion of the Revenue for Reform buy out would enable safety net hospitals to retain revenue to be redeployed for community and social needs that better serve a vulnerable population.
- Of the remaining 6-8 hospitals that may incur a penalty under the Integrated Efficiency policy, only one hospital would be considered a safety net hospital.

Application of TCOC

All letters (CareFirst, JHHS, MHA, Mercy, and UMMS) that addressed staff's recommendation to incorporate TCOC attainment and improvement in the Full Rate Application and Integrated Efficiency policy supported the proposal.

While supportive of the staff's proposal, JHHS raised one concern that in the Full Rate Application Methodology hospitals that have some of the lowest TCOC in the state still must reduce their TCOC faster than the statewide average improvement. They believe that staff should consider a modification to that methodology to allow for some lower threshold for hospitals with the lowest TCOC in the state.

Staff Response:

Staff appreciate that all stakeholders that opined on the proposed modification and characterized it as an improvement to the efficiency methodologies. While staff are sympathetic to JHHS' concern that low TCOC hospitals are not necessarily rewarded in the Full Rate Application policy. Staff note that the point of scaling a hospital's ICC evaluation by its performance in TCOC is to recognize actions taken by the Model to affect TCOC. While staff recognized this for downside risk when first promulgating the policy in 2021, staff failed to recognize this for upside risk, thereby creating an asymmetrical policy. Staff is correcting this error with broad support of stakeholders in this policy recommendation.

Revenue for Reform

All letters (CareFirst, JHHS, MHA, and UMMS) that addressed staff's recommendation to incorporate a population health buyout provision for the Integrated Efficiency policy expressed support for the proposal.

UMMS stated that by providing these facilities with an opportunity to retain revenue, the offset option allows hospitals to keep revenue where it is needed most and re-invest in activities that would directly

benefit the health of the population.

MHA suggested modifying the full rate application to include population health investments as phase II adjustments. Should the Commission not advance this proposal, such investments would not be recognized for efficient hospitals, creating inequities across policies.

CareFirst noted that they view the qualifying population health investment buyout from inflationary reductions as an introduction to more significant policy enhancements.

JHHS stated that there should be some limit to how much of the dollars identified through the Efficiency Policy can be offset, Also, policy as drafted does not address retained revenue that has accumulated since the inception of GBR. In addition, the Regional Entity Safe Harbor should be explored as an opportunity to redirect retained revenue that should have been but was not invested in population health programs.

Staff Response:

Staff appreciate that all stakeholders supported the proposed Revenue for Reform policy. Staff disagrees with MHA's assertion that population investments should be considered in Phase II negotiations with staff during full rate applications. This proposal overlooks that Full Rate Applications are used to reset hospital rates for current acute care services; it is not a process for simply seeking additional seed funding. Staff have already allowed low-cost hospitals to access additional funding for population health investments through the Integrated Efficiency policy.

Staff understand CareFirst and JHHS' concern that additional retained revenue should be dedicated to population health investments but note that more work needs to be done to define and quantify all retained revenue, and all necessary hospital investments, e.g., physician subsidies, should be ascertained before requiring larger investments from retained revenue.

Productivity Adjustment

All hospital stakeholders that addressed the policy decision of a productivity adjustment disagreed with staff's recommendation. CareFirst supported the adjustment.

CareFirst stated that over the last four years, roughly a quarter of hospitals would have qualified under these criteria each year. Thus, the 8% baseline does not require an unreasonable level of performance; it is attainable.

All hospital stakeholders echoed Holy Cross' assertion that the productivity adjustment was suspended in January of 2021"until the staff could develop an 'allowed unregulated subsidy' to account for population

health investments including physician costs."

Holy Cross, MHA, and Tidal Health also asserted that the reduced margins in RY 2022 are not due to operational inefficiencies, but rather the underfunding of inflation.

Staff Response

Staff appreciate CareFirst's insightful observation that over the last four years more than 25% of the hospitals have had operational efficiencies that exceeded the standard staff has put forth. This standard is not "simply a tool to make qualification for rate relief more difficult," as suggested by Holy Cross and Tidal Health, but rather a safeguard against providing rate enhancements for average cost performance, as was the previous justification for the 2% productivity adjustment.

Staff do not agree with the assertion that margin erosions in RY 2022 are due to underfunding of inflation. Cumulative inflation was underfunded by only approximately 1%. There have been significant increases in length of stay and use of agency nurses, which are potentially indicative of operational inefficiency.

All hospitals have measures of retained revenue that have likely not been converted into retained earnings, i.e., they are additional operational efficiencies that hospitals could achieve under this system by eliminating fixed costs. The Commission has decided that the appropriate funding of inflation is in the Update Factor; it is not the function of the Full Rate Application to undo this judgement,

Staff concurs that the productivity adjustment was suspended, not terminated, so that staff could develop a potential adjustment that allowed an unregulated subsidy for necessary physician subsidies and population health investments. However, the original genesis for the suspension was Commissioners' concern that requiring hospitals to achieve more than 10% operational efficiency was too stringent a standard.

The work to quantify potential unregulated subsidies has been delayed because hospitals repeatedly expressed that they did not have the capacity during the pandemic to develop additional policies and reporting structures.

The final recommendation in January of 2021 required the Commission to temporarily suspend the productivity adjustment and that "staff will report back to the Commission with a proposed substitute for the productivity adjustment.no later than July of 2023." Staff believe that it has complied with its mandate, and that the Commission should adopt its proposed, empirically based substitute for the productivity adjustment.

One-time Adjustment

Holy Cross, MHA, and Tidal Health disagreed with staff's recommendation to implement all efficiency adjustments in RY 2024 on a one-time basis. JHHS, MedStar, and UMMS supported the recommendation but the latter two noted that there should be a pathway to permanent rate increases, i.e., filing a full rate application.

Holy Cross and Tidal Health likened this proposal to an extension of the full rate moratorium and have noted that staff's concerns over case weights, deregulation adjustments, and the demographic adjustment are based on policy decisions and have not been equitably applied across policies. For example, the Commission has implemented market shift, the demographic adjustment, the MPA, and CTIs.

MHA pointed out. that under this proposal hospitals eligible for permanent rate relief may be reluctant to make permanent decisions, like raising nursing wages, if ongoing dollars are not guaranteed. MHA also stated if HSCRC wants to delay permanent rate adjustments because volumes are not stable, then it must follow its rule making process and propose to extend the moratorium via regulation, which MHA does not support.

Staff Response:

Staff appreciate UMMS', JHHS', and MedStar's recognition that the data volatility in this period is potentially problematic.

However, Staff note that the MPA and CTIs are one-time adjustments, and that the market shift adjustment is less confounded by the data issues raised by Staff, so the data considerations are less impactful.

Staff are sympathetic to MHA's position that hospitals cannot make permanent investment decisions based on one-time revenue and agree that the Commission would need to extend the moratorium period to prevent hospitals from filing a full rate application to access permanent changes to rate structures. For those reasons, staff has revised the policy recommendation to:

Implement all efficiency adjustments in RY 2024 on a permanent basis in July 2023 rate orders. This action would be contingent on hospitals, which are receiving rate enhancements, agreeing not to file full rate applications until January 2025. Staff also reserve the right to re-evaluate revenue in RY 2025, subject to appropriate Commission approval, for hospitals receiving permanent adjustments. Staff will determine whether efficiency evaluations change materially over the next year due to movements in the data as results stabilize post-pandemic.

Aligning Revenue and Volume

Adventist expressed concern about the mismatch between revenue and volume in the ICC. While in most years, the six months difference between the calendar year-based market shift revenue adjustment and the fiscal year-based volumes used in the ICC are immaterial, many hospitals experienced significant volume fluctuation in volume during the July-December 2022 period, driving large market shift adjustments.

Adventist believes that the Staff should bring the underlying ICC volumes forward to CY 2022 to match the revenue adjustments reflected in the CY 2022 market shift adjustment in the draft policy.

Staff Response:

Staff agree with Adventist's concern but would note that arguably the most important statistic in the ICC is regulated profit margin, which cannot be ascertained from CY 2022 for the vast majority of hospitals and allows the Commission to develop a cost per case standard. However, Staff propose to amend the process by:

Utilizing the RY 2022 volumes and the market shift adjustment attributable to the first six months of CY 2022, thereby matching the volume and revenue.

Data Concerns and Efficiency Evaluation

Holy Cross and Tidal Health asserted that the potential data issues in efficiency policies were due to Commission policy decisions. Staff believe most of these contentions are inaccurate; however, Staff agree with one data concern raised in the Tidal Health letter.

Assertion: When the Commission updated case weights in March 2023 to reflect the impact of an updated APR-DRG grouper version, it elected to use a pre-COVID volume period (CY2019) in lieu of a more current time-period (CY2022).

Staff Response:

This assertion suggests a lack of understanding of HSCRC data delays and the weight development process. Normally, CY data is not available to the Commission until 4 months after the year end, i.e., April. This year, due to data delays from Holy Cross, the data was not available until May. Typically, the weight development takes three to six months to program and validate, thus making use of CY 2022 data for efficiency adjustments in RY 2024 a virtual impossibility.

Assertion: Hospitals are required to notify the HSCRC of changes in service offerings or when services are shifted to or from a hospital-based setting. The policy statement by the staff assumes that 41 hospitals have not been compliant with HSCRC requirements or that staff have not adjusted for disclosed shifts of services. The breadth of this issue has not been quantified, yet the staff recommendation seeks to further delay rate relief for low-cost hospitals based on an unknown potential impact.

Staff Response:

Again, this assertion suggests a lack of understanding of what constitutes a deregulation adjustment and the evidentiary burden to implement a deregulation adjustment. Deregulation can occur if a hospital actively engages in moving services to an unregulated setting, but it can also occur if contractual providers elect to no longer refer patients to a hospital, the latter of which does often occur and is more difficult for the hospital to recognize in real time. Additionally, the HSCRC could not base its deregulation adjustments on CY 2021 data due to the significant declines experienced across all sites of service in that calendar year. Finally, the Commission only has access to Medicare TCOC claims data in real time, thus extrapolation, which is prone to protest, is required to adjudicate deregulation adjustments with hospitals.

Assertion: The Staff were also concerned about the impact of the Demographic Adjustment catch-up; however, the Commission voted to restore the demographic adjustment and, therefore, these amounts can be reflected in the updated ICC calculation.

Staff Response:

Staff agree that since the Commission has elected to approve the full catch-up for 2010-2020 census, staff can update the ICC, thus ensuring that hospitals are not paid for population growth twice, once through the Demographic Adjustment, and once through an efficiency evaluation that had not yet scored funding for population growth.

As such, staff have incorporated the following changes to the ICC.

- Changing the permanent revenue assessed in the ICC to account for the Demographic Adjustment catch-up.
- Restating the profit margin statistic under a pro forma assumption that all demographic adjustment funding, should it have been provided in prior years, would have altered profitability.
- Revising the productivity adjustment from 1.53 percent to .34 percent given the pro forma profit statistic is now 7.66 percent versus 6.46 percent.

Due to this rather substantial change and the change staff made to better line up revenue and volume in the ICC, per Adventist's request. staff have remodeled the efficiency policies with these technical adjustments.

Staff's final recommendation is as follows:

1. Provide TCOC Adjustments in the Full Rate Application policy based on a hospital's positive performance in attainment and improvement.

    a. Positive rewards for Medicare TCOC will be provided to hospitals that perform better than the Medicare Benchmark and grow slower than the average State Medicare TCOC.

    b. Positive rewards for Commercial TCOC will be provided to hospitals that perform better than the Medicare benchmark, better than the average of top half of commercial TCOC benchmarks and are growing slower than the average State Commercial TCOC.
    c. All other existing TCOC aspects of the Full Rate Application analysis will remain the same, including capping all rewards so that a hospital does not exceed its Medicare Benchmark

2. Utilize a revised TCOC assessment for the Integrated Efficiency Policy (IEP) that considers both attainment and improvement performance.

    a. Medicare TCOC performance will be based on the better of a benchmark attainment assessment and improvement performance captured through a metric analogous to the Medicare Performance Adjustment method (MPA)
    b. Commercial TCOC performance will be based on the better of a benchmark attainment assessment and improvement performance captured through a Commercial TCOC assessment analogous to the Medicare MPA approach.

3. Amend a hospital's penalty under the IEP to reflect the amount of eligible qualifying population health investments it makes. Qualifying population health investments should not be subject to inflationary reductions, as outlined in the Integrated Efficiency policy.

    a. Qualifying population health investments should meet all the following (the specifics of these conditions are explained in much greater detail below, and this additional detail would be used to govern admitted investments):

        - Non-physician community spending in the hospital's primary service

area incurred outside of the regulated space and cost accounting, net of revenue generated for those services,

- Spending that meets one of three following criteria:
    1) An initiative that is intended to address an unmet health need identified on either the hospital's Community Health Needs Assessment or the Centers for Disease Control and Prevention's Health People 2030 Initiative; or
    2) Spending on primary care (as defined by the Maryland Primary Care Program), mental health, or dental providers that are in a Medically Underserved Area; or
    3) Spending on a regional entity to improve population health.

The Maryland Department of Health (MDH) is eager to partner with Staff on the "Revenue for Reform." They asked that Staff give MDH a month so they can review the revenue policy and come back with Staff at the September Commission meeting with an implementation plan.

4. Reinstate a productivity adjustment in the ICC equivalent to the variance between the historical operational efficiency standard of 8 percent and the statewide regulated margin for ICC evaluated hospitals. The productivity adjustment is intended to evaluate operational efficiency in Full Rate Applications.

5. All RY 2024 efficiency adjustments will be processed as permanent adjustments.

    a. Hospitals eligible for a rate enhancement through the full rate application policy in RY 2024 can access funding through a streamlined process if the hospital agrees to: the value established by the methodology; no additional methodological considerations will be considerations; and the hospital will not file any subsequent rate request until January 1, 2025.
    b. However, Staff reserve the right to re-evaluate revenue in RY 2025, subject to approval by the Commission, for hospitals receiving a permanent adjustment, if efficiency evaluations change materially over the next year due to movements in the data as results stabilize post-pandemic.

Brett McCone, Senior Vice President Health Care Payment, MHA, disagreed with the Staff's inclusion of the productivity adjustment in the ICC calculation of hospital approved revenue. Mr. McCone requested that Staff further examine cost findings before the productivity adjustment is re-implemented; however, he also acknowledged that this adjustment has historically existed within the ICC calculation.

Commissioner Johnson proposed that as the efficiency policies evolve, staff should further consider individual cost categories and specific investments within total hospital costs. Mr. Johnson highlighted the need for the HSCRC to incentivize additional community investment, improve data collection operations, increase transparency around specific investments and around investment impact.

Chairman Kane agreed and further emphasized the need for improved data collection specific to physician losses.

Dr. Steve Leonard, President & Chief Financial Officer, TidalHealth, commended on Staff's decision to provide revenue enhancements on a permanent basis. Dr. Leonard noted that despite significant population health efforts, TidalHealth Peninsula Regional continues to experience volume growth. Dr. Leonard asserted that other facilities face similar circumstances, in which the hospital is efficient under the Staff's methodology but has little to no retained revenue due to volume growth.

Mr. Pack noted that Staff will work with stakeholders to develop a formal Revenue for Reform safe harbor application and bring back an implementation plan at the September 13th public meeting.

Commissioner McCann stated that she has concerns about the data volality but is willing to support the Staff recommendation. She hopes that Staff revisit the methodology in the future when more stable data can be used to assess if the Staff's outcome was accurate.

The Commissioners voted unanimously in favor of Staff's recommendation.

ITEM VI
REGIONAL PARTNERSHIP – CY 2022 REPORT

Ms. Erin Schurmann, Chief Provider Alignment and Special Projects, presented a summary of the CY Year 2022 Regional Partnership Catalyst program activities (see "Program Regional Partnership Catalyst Program- Calendar Year 2022 Activities-Final Report" available on the HSCRC website)

The HSCRC created the Regional Partnership Catalyst Program (Catalyst Program) to advance the population health and health equity goals of the Total Cost of Care (TCOC) Model and to encourage and support public-private partnerships that can create sustainable initiatives to improve the health of Marylanders. The Catalyst Program funds hospital-led teams to advance two population health priority areas that are part of the Statewide Integrated Health Improvement Strategy (SIHIS):

1. diabetes prevention and management and
2. behavioral health crisis services.

Teams include neighboring hospitals and community organizations such as local health departments (LHDs), local behavioral health authorities (LBHAs), non-profit and social service organizations, and provider groups to develop and implement interventions. Goals of the Catalyst Program include:

- Partnerships and strategies that result in long-term improvement in the population health metrics of the TCOC;
- Increased number of prevention and management services for persons at risk for or living with diabetes;
- Reduced use of hospital emergency departments (EDs) for behavioral health and improved approaches for managing acute behavioral health needs;
- Integration and coordination of physical and behavioral health services to improve quality of care; and
- Engagement and integration of community resources into the transforming healthcare system.

The Catalyst Program builds on the HSCRC's Regional Partnership Transformation Grant Program, launched in 2015 to reduce potentially avoidable utilization and per capita costs and demonstrate a positive return on investment through increased Medicare savings. The Regional Partnership Transformation Grant Program funded fourteen hospital-led partnerships, involving 41 of Maryland's acute care hospitals. Interventions were diverse, spanning behavioral health integration, care transitions, home-based care, mobile health, and patient engagement/education strategies focused on high-need and high-risk Medicare patients.

After the Regional Partnership Transformation Grant Program's expiration in June 2020, the HSCRC established the Catalyst Program to enable hospital-led partnerships to continue to build infrastructure in support of the population health goals of the TCOC Model and Statewide Integrated Health Improvement Strategy (SIHIS) in a more focused manner. The Catalyst Program made awards under two funding streams: (1) diabetes prevention and management; and (2) behavioral health crisis services. The Catalyst Program is based on the HSCRC philosophy of fostering collaboration among hospitals and community partners while creating infrastructure to disseminate evidence-based interventions.

The HSCRC awarded a cumulative $157.6 million through nine awards to eight Regional Partnerships to twenty-four hospitals for the five-year period of January 2021 through December 2025. Five of the nine awards fall under the diabetes prevention and management funding stream. These awards total $78.5 million and involve 24 hospitals. They span Western, Central, and Southern Maryland as well as the Capital Region. Three of the nine awards fall under the behavioral health crisis services funding stream. These three awards total $79.1 million and involve 24 hospitals. They span Central Maryland, portions of the Capital Region, and the Lower Eastern Shore.

The diabetes prevention and management funding stream support Regional Partnerships implementing the Centers for Disease Prevention & Control (CDC) recommended Diabetes Prevention Program (DPP). DPP has shown long-term success in helping to prevent the onset of diabetes and promote weight-loss for those with pre-diabetes. Maryland needs significantly more diabetes prevention and management resources for the State's prediabetic population.

This funding stream also supports implementation of Diabetes Self-Management Training (DSMT) and Diabetes Self-Management Education and Support (DSMES). DSMT/ES provides lifestyle change help and diabetes management curriculum to patients to help better control their Type II diabetes. Regional Partnerships under the Catalyst Program were required to achieve American Diabetes Association (ADA) or American Association of Diabetes Education (AADE) accreditation for their respective DSMT and DSMES programs, or to partner with an accredited program.

Funding is available for wraparound services to bolster the impact of DPP and DSMT/ES. For example, Medical Nutrition Therapy (MNT) could be provided as a wraparound service for patients participating in DSMT/ES. It is provided by registered dietitians as an intensive, focused, and comprehensive nutrition therapy service. MNT delivered concurrently with DSMT/ES has been shown to increase the ability of patients to manage their diabetes. Additional wraparound services support patient success in DPP and DSMT/ES include healthy food access, exercise programs, and transportation services to in-person classes.

DPP and DSMT/ES offer Regional Partnerships as a pathway to sustainability via Medicare, Medicaid and/or commercial payer reimbursement. However, Medicare billing requires suppliers to make substantial investments in certification, training, and administration. Catalyst Program funding helps build this infrastructure by supporting start-up costs, including recruitment, training, and certification.

HSCRC set a goal for Regional Partnerships to refer five percent of their prediabetic patient population to DPP in 2022. Referrals are measured in targeted ZIP codes that were self-selected by Regional Partnerships in their 2020 proposals. There is a significant number of referrals being generated outside of targeted ZIP codes that the Regional Partnerships do not receive credit for since the measurement is ZIP code based.

In 2022, Regional Partnerships referred a total of 7,224 patients to DPP in designated ZIP codes. Referrals to DPP are inclusive of all-payers (Medicare, Medicaid, commercial, self-pay, uninsured) and are self-reported by Regional Partnerships monthly. This is an increase of 1,099 patients from the FY 2022 target amount.

HSCRC continues to use all-payer referrals as a performance metric in CY 2023 and monitors Medicare and Medicaid claims to evaluate DPP enrollment. Progress to establish new billing processes for DPP has

been slower than anticipated. All Regional Partnerships are expected to provide progress reports this summer. Staff will review these plans and will ask for corrective action plans for Regional Partnerships where there is a lack of progress.

On an all-payer basis, statewide cumulative enrollment in DPP has increased steadily since the Catalyst Program began in 2021 and is currently outpacing the nation.

Maryland currently lacks the infrastructure needed to divert behavioral health crisis needs from EDs and inpatient settings to more appropriate community-based care. Community-based organizations often do not receive reimbursement for crisis management services and struggle to gain the capacity needed in Maryland. The TCOC Model incentivizes reductions in unnecessary ED and hospital utilization. Hospitals across Maryland cite opioid use and inadequate access to acute mental health services as contributors to ED overcrowding.

The behavioral health crisis services funding stream supports development and implementation of infrastructure and interventions consistent with the "Crisis Now: Transforming Services is Within Our Reach" action plan developed by the National Action Alliance for Suicide Prevention. Regional Partnerships are implementing one or more of the following:

- Air Traffic Control (ATC) Capabilities with Crisis Line Expertise. The ATC model is based on always knowing the location of an individual in crisis and verifying hand-offs to the next provider. The model creates a hub for deployment of mobile crisis services and access to other services such as crisis stabilization. The model's essential components include qualified crisis call centers and 24/7 clinical coverage with a single point of contact for a defined region. ATC is also referred to as "Care Traffic Control" by one Regional Partnership.
- Community-Based Mobile Crisis Teams. 3 Mobile crisis services deploy real-time professional and peer intervention to the location of a person in crisis. They are intended to avoid unnecessary ED use and hospitalization.
- Stabilization Centers. Crisis stabilization services provide 24-hour observation and supervision at a sub-acute level to prevent or ameliorate behavioral health crises and/or address acute symptoms of mental illness. Settings are small and home-like relative to institutional care.

Significant progress was made on care traffic control and open access activities. The 988 Regional Call Center for Central Maryland went live in April 2023, establishing a regional Care Traffic Control system by implementing a single hotline for substance use and mental health crisis calls. It averages 55 calls per day, an increase from the number of calls to separate 988 operators prior to implementation. Work completed during CY 2022 included competitively procuring a vendor contract to operate the 988 Regional Call Center and negotiating the MOU.

Mobile crisis team response volume grew dramatically over CY 2022 to divert patients from the ED who do not require a high-level intervention. In Prince George's County, TLC is funding four operating mobile crisis teams. They work in close collaboration with law enforcement and EMS, with standard operating procedures around scene sharing and best practice protocols for the emergency crisis continuum. In October 2022, the Regional Partnership changed the mobile crisis team business model to be standalone, as opposed to part of the call center. This change was motivated by regulation and reimbursement requirements. The change also facilitated the mobile crisis team's increasing workforce. Incorporating dispatch into the mobile crisis team system increased coordination of services. The new standalone mobile crisis team can now receive calls directly instead of having to be routed through the 988 Call Center. After launching the new mobile response times in Fall 2022, in-person, and virtual interactions with patients in crisis increased significantly. In CY 2022, monthly dispatches increased from 11 in January to 240 in December, totaling 1178 dispatches. A total number of 1751 patients were served by mobile response teams in CY 2022, growing from 52 in January to 432 in December.

During CY 2022 Regional Partnerships advanced the sustainability of Catalyst Program behavioral health initiatives. Beginning in CY 2021, Regional Partnerships coordinated with the broad-based effort to establish a statewide mechanism to fund 988 in Maryland. The "Fund Maryland 988 Campaign" brings together more than 70 partner organizations to establish a Maryland 988 Trust Fund. The campaign advocated for legislation during the 2022 and 2023 General Assembly sessions to lay the groundwork for sustainable funding. In 2022, the General Assembly passed legislation to establish a 988 Trust Fund and appropriated $5.5 million for the 988 Lifeline in FY2023.

ITEM VII
UNCOMPENSATED CARE REPORT – FY 2024

Ms. Prudence Akido, Chief Research and Methodology, presented a review of the FY 2024 Uncompensated Care Report (see" Rate Year 2024 Uncompensated Care Report" available on the HSCRC website).

The Uncompensated Care Policy was created by the HSCRC to recognize the financial burden borne by hospitals from the continued provision of high-quality hospital care to patients who cannot afford to pay for it and to create a financial reimbursement for the provision of Uncompensated Care (UCC) into the rates the Commission sets for hospitals. The UCC policy is a fundamental element of equity built into the all-payer system and has continued under the Total Cost of Care Model. The purpose of this report is to provide background on the UCC policy and to provide hospital-specific values for the UCC built into statewide rates as well as the amount of funding that will be made available for the UCC pool, the latter of which ensures the burden of uncompensated care is shared equitably across all hospitals. UCC is hospital care provided for which no compensation is received and constitutes a combination of charity

care and bad debt.

Charity care services are those Commission regulated services rendered for which payment is not anticipated. Charity care is provided to patients who lack health care coverage or whose health care coverage does not pay the full cost of the hospital bill. Free and reduced care are two types of charity care that occurs across all payers.

The other type of Hospital UCC is bad debt, which is Commission regulated services rendered for which payment is anticipated. But which payment is not received. The cost for unpaid services provided to patients who do not meet the charity thresholds are charged off as bad debt after the hospital makes a reasonable attempt to collect the charges.

HSCRC's UCC policy assures access to hospital services in the State for those patients who cannot readily pay for them and equitably distributes the burden of uncompensated care costs across all hospitals and all payers. This approach ensures that hospitals with high volumes of low-income patients are not at a financial disadvantage. For RY 2024, the UCC amount to be built into rates for Maryland hospitals is 4.29 percent.

Staff are evaluating the possibility of using multi-year actual UCC averages instead of the one-year figures currently utilized in the policy due to recent upward trends in UCC. Using multiple years will make the statistics more stable, especially as the effects of the Affordable Care Act implementation appear to have dissipated. Further, Staff believe that this approach will help control for anomalies, such as the impact of COVID-19 on hospital utilization. This change will be considered for the RY 2025 UCC Funding Policy, pending stakeholder input and Commission approval.

ITEM VIII
POLICY UPDATE AND DISCUSSION

EMERGENCY ROOM WAIT TIMES INITIATIVES

Dr Alyson Schuster, Deputy Director, Quality Methodologies and Dr Geoff Dougherty, Deputy Director, Population-Based Methodologies, Analytics, and Modeling presented an update on strategies to address Emergency Department performance (see "Strategies to Address Emergency Department Performance" available on the HSCRC website). The state legislature has asked Staff and MHA to convene a workgroup to identify solutions to improve hospital Emergency Department (ED) performance.

The workgroup will address:

- ED challenges due to significant lack of statewide Emergency Medical Services units.

- Developing payment policies for ED wait times and avoidable ED for CY 24
- Identifying short-term policies that could spur rapid city improvement.

To help improve the ED performance the workgroup developed the Emergency Department Dramatic Improvement Effort (EDDIE) project. The workgroup will implement EDDIE in July/August. EDDIE is a short-term reporting project which will be used for conversation and input. The areas to be address are as follows:

Monthly, public reporting of three measures:

- ED1 Inpatient arrival to admission time
- OP18 Outpatient ED arrival to discharge time.
- EMS turnaround time (data from Maryland Institute for Emergency Systems)

Reports received for June data: 43 out of 44 hospitals/EDs reported data.

- 41 hospitals reported ED1a (16 hospitals noted the data was preliminary, another anomaly, or said the data was pending final validation).
- 42 hospitals reported OP18a (15 hospitals noted the data was preliminary, another anomaly, or said the data was pending final validation).
- One hospital requested an extension.
- Future reporting needs to be requested from all freestanding EDs.

June data shows that: ED 1a: ED Arrival to Admission time per hospital ranged from 200 minutes to over 1,200 minutes.

June data shows that OP 18a; ED arrival to discharge time per hospital ranged from 100 minutes to over 400 minutes.

Next Steps

- Address reporting questions and concerns with hospitals.
- Clarify specifications related to observation stay.
- Incorporate all freestanding Eds.
- Modify or provide additional analyses for Commissioners as requested.
- Present monthly improvements • Focus on data stratified by behavioral health.
- Invite speaker to future Commission meetings - (Ex High performing hospital, MHA, MIEMSS) Collaborate with MHA on legislative request and EDDIE quality improvement initiative.

MARYLAND MODEL PERFORMANCE CY2022 – UPDATE

Ms. Wunderlich stated that Staff is working with the Center of Medicare and Medicaid Innovation (CMMI) to finalize the data concerning the state's performance on the Maryland Total Cost of Care for CY 2022.

Ms. Wunderlich stated that once the data is finalized, CMMI will send out a memo concerning the state's performance regarding the TCOC for CY 2022. She anticipates this memo to be sent out by the end of July.

KATIE WUNDERLICH

Chairman Kane announced that Ms. Wunderlich will be leaving the Commission. Chairman Kane and the Commissioners expressed their immense gratitude for the tremendous work that Ms. Wunderlich accomplished during her time as Executive Director. They specifically noted her successful work in navigating the Commission through the challenging period of COVID, refining the Maryland Model, and reducing utilization throughout the State.

ITEM VIII
HEARING AND MEETING SCHEDULE

August 9, 2023, Canceled

September 13, 2023, Times to be determined- 4160 Patterson Ave.
HSCRC Conference Room

There being no further business, the meeting was adjourned at 4:35 p.m.

Closed Session Minutes
of the
Health Services Cost Review Commission

July 12, 2023

Upon motion made in public session, Chairman Kane called for adjournment into closed session to discuss the following items:

1. Discussion on Planning for Model Progression– Authority General Provisions Article, §3-103 and §3-104

2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

3. Update on Commission Response to the COVID-19 Pandemic – Authority General Provisions Article, §3-103 and §3-104

The Closed Session was called to order by motion at 11:03 a.m.

In attendance via conference call in addition to Chairman Kane were Commissioners Antos, Johnson, Joshi, McCann, and Sharfstein.

In attendance representing Staff were Katie Wunderlich, Jerry Schmith, Allan Pack, William Henderson, Will Daniel, Claudine Williams, Alyson Schuster, Ph.D., Megan Renfrew, Erin Schurmann, Cait Cooksey, Bob Gallion, and Dennis Phelps.

Also attending were:
Eric Lindemann, Commission Consultant, and Stan Lustman and Ari Elbaum Commission Counsel.

Item One

Executive Director Katie Wunderlich introduced the new Commissioners Micky McCann and Josh Sharfstein.

Item Two

Katie Wunderlich and staff summarized the TCOC Model financial and quality targets and federal reporting requirements. Ms. Wunderlich outlined the goals and performance of the statewide Integrated Health Improvement Strategy. Staff

summarized and the Commission discussed per capita, and risk adjusted readmission analyses.

Item Three

Eric Lindemann updated the Commission and the Commission discussed Maryland Medicare Fee-For-Service TCOC versus the nation.

Item Four

William Henderson, Director, Medical Economics & Data Analytics, described the drivers of Medicare FFS savings since 2013.

The Closed Session was adjourned at 1:07 p.m.

Cases Closed

The closed cases from last month are listed in the agenda

maryland
health services
cost review commission

Staff Recommendation: Encompass Health Corporation Bowie

Dennis Phelps

Deputy Director, Audit & Integrity

To be Effective: June 13, 2023

September 13, 2023

Staff Recommendation for Encompass Health Corporation for Waiver from HSCRC Rate Setting

Background

- On July 3, 2023, Encompass Health Corporation (“Encompass Health”) filled an application to:
  - Establish a permanent rate structure for a new rehabilitation hospital in Bowie Maryland, effective June 13, 2023, and
  - Exemption from HSCRC rate setting, pursuant to COMAR 10.37.03.10.
- Encompass Health currently operates a rehabilitation hospital in Rockville, Maryland
- Effective July 1, 2023, University of Maryland Rehabilitation Institute of Southern Maryland, LLC, a wholly owned subsidiary of University of Maryland Medical System, acquired a 50 percent ownership interest in Encompass Bowie.

Criteria for Exemption from Rate Setting (COMAR 10.37.03.10)

A hospital may file for an exemption if:

- More than 66 ⅔ percent of gross patient revenue is derived from governmental payers (Medicare and Medicaid) who are not required to pay HSCRC approved rates;
- Annual gross non-physician revenue is not greater than $20 million, in 1996 dollars;
- Annual gross revenue subject to HSCRC rate jurisdiction is not more than $5 million, in 1996 dollars;
- The terms of the regulation have been met for at least 12 consecutive months.

Application Request

- Encompass Health is requesting that the 12 months period be waived and that the exemption from HSCRC rate setting be effective retroactive to June 13, 2023.
- The bases for Encompass Health's request for the retroactive exemption from rate setting are as follows:
  - Encompass Salisbury and Adventist HealthCare have both been granted the rate setting exemption and have met the conditions of the regulation for more than 20 years; and
  - The actual payer mix at Encompass Salisbury for CY 2022 was mostly governmental payers (over 92 percent).

Staff Evaluation

Staff reviewed the supporting documents from Encompass Health and reviewed experience data from the two existing rehabilitation hospitals in Maryland, Adventist Healthcare and Encompass Salisbury.

- Based on this review, staff believes that Encompass Bowie will meet the conditions of the regulation in its first 12 months of operations.

Staff Recommendation

The staff recommends that the Commission approve the following:

- The rates be approved as requested, effective June 13, 2023;
- Encompass Health be exempt from rate setting, effective June 13, 2023;
- Encompass Health file with the HSCRC a copy of its audited financial statements 140 days after the end of its fiscal year;
- Encompass Health files the required monthly case mix data, as described on the HSCRC website;
- Encompass Health files a report 30 days after the end of each calendar quarter affirming that the payer-mix meets the Regulation criteria; and
- The continuation of the rate setting exemption be contingent on the results of the Hospital's financial and case mix reporting.

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**
NEW RATES AND EXEMPTION FROM	*****	**SERVICES COST REVIEW**
HSCRC RATE SETTING	*****	**COMMISSION**
ENCOMPASS OF BOWIE, LLC	*****	**DOCKET: 2023**
BOWIE, MARYLAND	*****	**FOLIO: 2436**
	*****	**PROCEEDING: 2926R**

Staff Recommendation

September 13

I. INTRODUCTION

On July 3, 2023, Encompass Health Corporation ("Encompass Health") filed an application with the Health Services Cost Review Commission ("HSCRC") to establish a permanent rate structure for a new 60 bed rehabilitation hospital, Encompass Health Rehabilitation Hospital of Southern Maryland (Encompass Bowie), to be effective June 13, 2023. Effective July 1, 2023, University of Maryland Rehabilitation Institute of Southern Maryland, LLC, a wholly owned subsidiary of University of Maryland Medical System, acquired a 50 percent ownership interest in Encompass Bowie. Encompass Bowie began admitting patients on June 13, 2023.

In addition, Encompass Health also applied for a rate setting exemption pursuant to COMAR 10.37.03.10 (the "Regulation"). Under the Regulation, the HSCRC may on its own or a hospital may file an application to request that rates for services to be **exempt from HSCRC jurisdiction rate setting, if the all of following conditions are met**:

- More than 66 ⅔ percent of annual gross patient revenue is derived from Medicare, Medicaid, or both, who are not required by State law, the Model, or the Medicare waiver to pay Commission approved rates for those services;
- The annual gross revenue for non-physician services is not more than $20 million (in 1996 dollars adjusted by the appropriate index of inflation);
- The gross revenue subject to HSCRC jurisdiction is not more than $5 million (in 1996 dollars adjusted by the appropriate index of inflation); and
- The terms of the Regulation have been met for a minimum of 12 months before the application is filed.

II. BACKGROUND

Encompass Health is the largest owner and operator of rehabilitation hospitals in the country. Encompass operates 158 rehabilitation hospitals including one in Maryland, the 74 bed Encompass Health Rehabilitation Hospital of Salisbury (Encompass Salisbury). Encompass Salisbury is one of only two rehabilitation hospitals in Maryland. The other is Adventist HealthCare Rehabilitation Hospital in Rockville. Both Encompass Salisbury and Adventist HealthCare have been exempted from HSCRC rate setting under the Regulation for more than twenty years.

III. FINDINGS

In support of its request, Encompass Health seeks a waiver of the requirement that the

conditions of the Regulation must be met for a minimum period of 12 months immediately preceding the request for exemption from rate setting. According to Encompass Health, Encompass Bowie will provide similar services that should result in a similar payer mix as its Encompass Salisbury hospital. The payer-mix for calendar year 2022 at Encompass Salisbury was as follows:

Medicare	91.9%
Medicaid	0.6%
Commercial	6.3%
Self-Pay/Other	1.2%

IV. STAFF EVALUATION

Based on the experience of the other two Maryland rehabilitation hospitals, Encompass Health Rehabilitation Hospital of Salisbury and Adventist HealthCare Rehabilitation Hospital, Staff believes that Encompass Bowie will be able to meet the conditions of the Regulation in its first year.

V. STAFF RECOMMENDATION

The staff recommends that the Commission approve the following:

1) The rates be approved as requested, effective June 13, 2023.
2) Encompass Health be exempt from rate setting, effective June 13, 2023.
3) Encompass Health file with the HSCRC a copy of its audited financial statements 140 days after the end of its fiscal year.
4) Encompass Health files the required monthly case mix data, as described on the HSCRC website.
5) Encompass Health files a report 30 days after the end of each calendar quarter affirming that the payer-mix meets the Regulation criteria.
6) That the continuation of the rate setting exemption be contingent on the results of the Hospital's financial and case mix reporting.

Encompass Health
Rehabilitation Hospital of Bowie

17351 Melford Blvd
Bowie, MD 20715

encompasshealth.com/locations/bowierehab

ENCOMPASS HEALTH REHABILITATION HOSPITAL OF SOUTHERN MARYLAND dba REHABILITATION HOSPITAL of BOWIE

RATE-SETTING EXEMPTION REQUEST

TO BE EFFECTIVE

JUNE 13, 2023

IN RE: RATE SETTING EXEMPTION REQUEST	*	BEFORE THE HEALTH SERVICES	
	*	COST REVIEW COMMISSION	
ENCOMPASS HOSPITAL OF BOWIE	*	SUBMISSION DATE: JUNE 30, 2023	
LLC	*	DOCKET NO.:	DOCKET DATE:
BOWIE, MARYLAND	*	FOLIO NO.:	PROCEEDING NO.:
	*		

* * * * * * * * * * * *

RATE SETTING EXEMPTION REQUEST
ENCOMPASS HEALTH REHABILITATION HOSPITAL OF SOUTHERN MARYLAND, LLC

SUMMARY OF RATE REQUEST

Encompass Health Corporation ("Encompass Health") hereby applies to the Health Services Cost Review Commission ("the HSCRC" or "the Commission") to establish a permanent rate structure for Encompass Health Rehabilitation Hospital of Southern Maryland ("Encompass Southern Maryland", or "the hospital") to be effective June13, 2023. This filing constitutes the written notice required by Maryland Annotated Code, Health-Gen. Art. § 19-219(a) and COMAR 10.37.10.05C.

In addition, Encompass Bowie hereby applies to the Health Services Cost Review Commission ("the HSCRC" or "the Commission") for a rate-setting exemption pursuant to COMAR 10.37.03.10. Under COMAR 10.37.03.10 a hospital may file an application to request that rates for services be exempt from Commission jurisdiction if the following conditions are met:

1. 66 2/3 percent or more of annual gross patient revenue attributable from either Medicaid or Medicare patients, or both, who are not required by State law or by terms of the Medicare Waiver to pay Commission approved rates for those service and;

2. Annual Gross revenue for non-physician services is not more than $20 million (in 1996 dollars), adjusted by an appropriate index of inflation or;
3. Annual gross revenue subject to Commission rate-setting jurisdiction is not more than $5 million (in 1996 dollars) adjusted by an appropriate index of inflation.
4. The terms of the regulation have been met for a minimum of 12 months before the application is filed.

As outlined in the request below, the Hospital believes it will meet the above requirements in the first 12 months of operations. Encompass is requesting that the Commission grant the exemption prospectively based on the projected payer mix and gross revenue as outlined in its May 21, 2020, approved Certificate of Need Application (CON). This request is further supported by the historical operations of our Encompass Health Rehabilitation Hospital of Salisbury. We intend to operate the Bowie specialty rehabilitation hospital with a similar payer mix as our existing hospital in Salisbury, Maryland. This hospital has been exempted under the same criteria by the Commission for over 20 years. As you can see below, the most recent calendar year 2022 payer mix for the Salisbury location is similar to our CON forecast for the new location in Bowie, Maryland.

DESCRIPTION OF REQUEST

Encompass Health Rehabilitation Hospital of Southern Maryland, LLC is a Delaware limited liability corporation and a subsidiary of Encompass Health Corporation (Encompass Health"), a publicly-traded, for-profit corporation. Encompass Health is the largest owner and operator of rehabilitation hospitals in the United States. Encompass Health operates 158 hospitals in 37 states and Puerto Rico. These hospitals include a 74-bed specialty acute care rehabilitation hospital, Encompass Health Rehabilitation Hospital of Salisbury, which is located in Wicomico County.

On May 21, 2020, the Maryland Health Care Commission (MHCC) approved a CON authorizing Encompass to construct and operate a 60-bed inpatient acute specialty rehabilitation hospital in Bowie, Maryland. In addition, MHCC approved two additional project modifications related to increases to the project budget on March 18, 2021, and May 19, 2022. On October 20, 2022, MHCC approved a second CON related to the project which will allow the hospital to expand to a total of 70 beds; however, the additional 10-bed expansion is not expected to be completed and implemented until some time in the spring of 2024. Neither the project modifications nor the expansion CON contained any modifications related to the expected payer mix for the hospital.

The specialty rehabilitation hospital in Southern Maryland officially began accepting patients on June 13, 2023. Encompass acknowledges that the request is retroactive in nature which represents an unintentional oversight of the need to request a set of rates and waiver from HSCRC regulation. Encompass Health is requesting that both the initial rates and exemption from HSCRC rate setting be effective June 13, 2023.

The basis for both the initial rate setting and exemption request is outlined below:

Initial Rate Setting

Establish a set of rates for Encompass Southern Maryland consistent with April 1, 2023 Statewide median unit rates. The proposed rates are outlined in Table A.

Table A – Requested Unit Rates

Rate Center		Projected Volume	Statewide Median Rate		Projected Revenue
ADM	Admission Services	904	$354.477		$320,447.21
AMR	Ambulance Services Rebundled	174	6.11		1,063
CDS	Drugs Sold	245,361	2.57	[1]	630,357
LAB	Laboratory Services	21,717	2.31		50,060
MSS	Medical Supplies Sold	593	1.93	[1]	1,145
OPM	Other Physical Medicine	585	41.11	[2]	24,048
OTH	Occupational Therapy	48,964	11.28		552,106
PTH	Physical Therapy	49,111	17.20		844,920
RAD	Radiology Diagnostic	565	26.05		14,718
RES	Respiratory Therapy	5,301	2.85		15,125
RHB	Rehabilitation	12,207	1,436.35		17,533,518
STH	Speech Therapy	15,668	13.23		207,278

Note 1: Reflected the charge to cost ratio
Note 2: Based on Encompass Health Rehabilitation of Salisbury

Projected admissions and patient days are consistent with the CON submission for Year 1 of operation. Ancillary volumes were projected based on utilization patterns of Encompass Health Rehabilitation Hospital of Salisbury. The Encompass Southern Maryland facility is expected to treat patients with a similar acuity to the Salisbury hospital.

Exemption from Rate Regulation

Encompass Health is requesting that the Commission grant the exemption from HSCRC regulation effective June 13, 2023. The basis for the exemption request would be the projected payer mix and gross revenue for the first year of operation.

For purposes of demonstrating that Encompass will meet the requirements outlined above in the first 12 months of operation, the key assumptions outlined in the original CON submission will be used to demonstrate that the criteria outlined above is met:

1. **66 2/3 percent or more of annual gross patient revenue attributable from either Medicaid or Medicare patients, or both, who are not required by State law or by**

terms of the Medicare Waiver to pay Commission approved rates for those service and;

Similar to other specialty hospitals in Maryland, Encompass is not included in the Maryland Demonstration Model and therefore Medicare and Medicaid are not required to pay HSCRC approved rates. As noted in the CON, Encompass projected that 83.5% (Medicare 79.8% and Medicaid 3.7%) of the revenue will be from Medicare and Medicaid patients which exceeds the 66 2/3 requirement noted above. Table B below summarizes the first year of operations projected payer mix as outlined in CON Table K FY2021.

Table B – Projected Payer Mix

Payer	Percent of Gross Revenue
Medicare	79.8%
Medicaid	3.7%
Blue Cross	6.1%
Commercial Insurance	9.5%
Self-Pay	0.9%
Other	0.0%
Total	100%

Further, our Encompass Health Salisbury specialty rehabilitation hospital has operated with a similar mix of Medicare and Medicaid revenue as shown in Table C below.

Table C – Calendar Year 2022 Actual Revenue Payer Mix

Payer	Percent of Gross Revenue
Medicare	91.9%
Medicaid	0.6%
Commercial Insurance	6.3%
Self-Pay/Other	1.2%
Total	100%

2. **Annual Gross revenue for non-physician services is not more than $20 million (in 1996 dollars), adjusted by an appropriate index of inflation or;**

The $20 million threshold based on 1996 dollars was inflated to 2022 dollars based on The CPI for All Urban Consumers (CPI-U), Medical Care in U.S. city average, all urban customers not seasonally adjusted as outlined in Table D below:

Table D: Price Leveled Annual Gross Revenue for non-physician services.

1996 threshold:	$20,000,000	a
2022 threshold:	$47,901,315	b = a * d / c
1996 index:	228.2	c
2022 index:	546.554	d

Gross revenue for the first year of operation based on Table K Revenue and Expenses is projected to be $25,031,314 well below the threshold above of $47,901,315.

3. **Annual gross revenue subject to Commission rate-setting jurisdiction is not more than $5 million (in 1996 dollars) adjusted by an appropriate index of inflation.**

The $5 million threshold based on 1996 dollars was inflated to 2022 dollars based on The CPI for All Urban Consumers (CPI-U), Medicare Care in U.S. city average, all urban customers not seasonally adjusted as outlined in Table E below:

Table E – Price Leveled Annual Gross Revenue Subject to Commission Rate-Setting Jurisdiction

1996 threshold:	$5,000,000	a
2022 threshold:	$11,975,329	b = a * d / c
1996 index:	228.2	c
2022 index:	546.554	d

Gross revenue subject to rate-setting jurisdiction in the first year of operations is projected to be $4,130,167 (16.5% times $25,031,314) which is well below the $11,975,329 threshold calculated above.

4. **The terms of the regulation have been met for a minimum of 12 months before the application is filed**

   Encompass Health is requesting that the 12 months experience requirement be waived given projected payer mix of 80% Federal payers and experience at the Encompass Salisbury location which treats a similar payer mix.

Encompass is requesting, based on the above information, to prospectively exempt Encompass from rate regulation based on projected payer mix and revenue effective June 13, 2023. In addition, Encompass agrees to comply with all HSCRC reporting requirements for acute care specialty hospitals exempt from rate setting. Encompass understands that if the hospital's payer mix or gross revenue fails to comply with the guidelines outlined above, the exemption request may be terminated by the Commission.

In accordance with HSCRC regulation, a Certificate of Service is hereby attached to this application representing that copies of this filing have been sent to the various Designated Interested Parties.

Respectfully Submitted,

Joseph Williams

Joseph Williams, RN, MHA, MBA, CRRN
CEO, Encompass Rehabilitation Hospital of Southern Maryland

6/30/2023

Date

ENCOMPASS HEALTH REHABILITATION HOSPITAL OF SOUTHERN MARYLAND - AMENDMENT

RATE-SETTING EXEMPTION REQUEST

TO BE EFFECTIVE

JUNE 13, 2023

IN RE: RATE SETTING EXEMPTION REQUEST	*	BEFORE THE HEALTH SERVICES
	*	COST REVIEW COMMISSION
ENCOMPASS HOSPITAL OF SOUTHERN MARYLAND LLC	*	SUBMISSION DATE: AUGUST 21, 2023
	*	DOCKET NO.: 2626R DOCKET DATE: 7/3/2023
BOWIE, MARYLAND	*	FOLIO NO.: PROCEEDING NO.:
	*	

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RATE SETTING EXEMPTION REQUEST
ENCOMPASS HEALTH REHABILITATION HOSPITAL OF SOUTHERN MARYLAND, LLC - AMENDMENT

Encompass Health Rehabilitation Hospital of Southern Maryland, LLC ("Encompass Bowie") hereby amends the previous rate application docket number 2626R to inform the Commission and designated interested parties of a change in ownership of Encompass Bowie. Effective July 1, 2023, University of Maryland Rehabilitation Institute of Southern Maryland, LLC (UM Rehab Southern Maryland) acquired a 50% ownership interest in Encompass Bowie. UM Rehab of Southern Maryland is a wholly owned subsidiary of University of Maryland Medical System.

The goal of the joint venture is to enhance the post-acute strategy and continuum of care for patients within the service area. The patient payer mix and acuity outlined in the Certificate of Need application will not be impacted by the joint venture. As a result, the requested initial rate setting and exemption from HSCRC rate setting outlined in the original rate application are not impacted by this amendment.

In accordance with HSCRC regulation, a Certificate of Service is hereby attached to this application representing that copies of this filing have been sent to the various Designated Interested Parties.

Respectfully Submitted,

Joseph Williams

Joseph Williams, RN, MHA, MBA, CRRN
Hospital CEO
Encompass Health Rehabilitation Hospital of Southern Maryland, LLC

8/22/2023

Date

CERTIFICATE OF SERVICE
TO INTERESTED PERSONS

I hereby certify that the foregoing Order of the Commission has been sent to the Hospital and to the following interested persons:

Brett McCone
Senior Vice President
Maryland Hospital Association
6820 Deerpath Road
Elkridge, Maryland 21075

Annette Anselmi
Executive Director
Maryland Health & Higher Educational
Facilities Authority
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Baltimore, Maryland 21202

Wynee Hawk
Director – Centers for Health Care Facilities
Planning & Development
Maryland Health Care Commission
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Baltimore, Maryland 21215

Arin Foreman
Senior Director, Regulatory Affairs
CareFirst BlueCross BlueShield
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Dated 8/22/2023

maryland
health services
cost review commission

Overview of Financial Assistance and Medical Debt Proposed Regulations

September 12, 2023

Megan Renfrew, Associate Director of External Affairs

Overview

- Timeline
- Legal and Political Context
- Goals and Principles
- Changes in Regulation since 2022 and Statutory Limitations to Additional changes.
- Appendix
  - Review of Financial Assistance Requirements and Recent Changes in Law
  - Review of Medical Debt Requirements and Recent Changes in Law
  - Enforcement

Development of Revised Regulations (COMAR 10.37.10.26)

2020-2021

- Legislature modified hospital financial assistance and medical debt statute

Summer 2022

- Stakeholder workgroup developed income-based payment plans guidelines
- Staff revised regulations
- HSCRC Meeting: Commissioners voted on publication of proposed regulations

Fall 2022

- Formal public comment period
- Staff reviewed comments

Spring/Summer 2023

- Staff reviewed comments (continued)
- Draft shared with Stakeholders
- Stakeholder meeting
- Staff review of stakeholder comments

Fall 2023

- September: Commissioners vote on publication of proposed regulations
- Regulations published for public comment

Legal & Political Context

- HSCRC has had statutory responsibility for financial assistance since 2005 and medical debt collection since 2009.
- The purpose of the statutory changes in 2020 and 2021 was to increase consumer protections.
    - In 2020, 15% of Maryland residents reported having medical debt (source: Economic Action Maryland).
    - Unlike some other forms of consumer debt, consumers often have limited ability to control their exposure to medical debt. Medical debt can negatively impact health.*
- 2020 and 2021 changes kept this work in HSCRC's statute.
    - Given our growing responsibilities in this area, we have improved our implementation and oversight and have plans for continued improvement.

* Mendes de Leon CF, Griggs JJ. Medical Debt as a Social Determinant of Health. JAMA. 2021;326(3):228–229. doi:10.1001/jama.2021.9011

Goals and Principles

Statutory Goals:

- Increase opportunities for patients to receive notice and apply for financial assistance
- Add procedural incentives for hospitals to ensure qualified patients receive financial assistance.
- Ensure affordable monthly payment plans.
- Increase consumer protections for patients from medical debt collection and protect basic family income and assets.

Principles for Regulations

- Operationalizing new statute, including reconciling new law with existing law
- Fairness for Patients
- Access & Affordability
- Clarity for industry on compliance with the law

Changes in Draft Regulations since 2022

- Both income-based and non-income based payment plans are allowed.
- Clarified calculation of income for income-based payment plans.
- Clarification of treatment of missed payments under income-based payment plans.
- Clarified treatment of prepayments before services are provided.
- Free care can not be limited to hospital service area residents.
- Financial assistance cannot be limited to urgent and emergent care.
- Allows use of the uniform financial assistance application OR a similar application.

Controversial Elements

Scope

- Hospital services
  - Inpatient, emergency department, and outpatient services “at a hospital”
  - Not professional services
- Maryland residents
- Prepayment plan
- Financial assistance: General acute and chronic care hospitals

Income Calculation

“Individual income” v. family income → pro-rata share to take household size into account.

Good Faith attempt to Comply

Required before the hospital-

- Delegates to “debt collector”
- Files a legal action to collect debt

Thank you!

- Megan Renfrew, Associate Director of External Affairs
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Appendix: Financial Assistance Requirements

Determining Financial Assistance Eligibility under HG 19-214.1

1. **Hospital service (HSCRC jurisdiction)**
   a. Not a professional service
   b. Inpatient service, ED Service, or outpatient service "at the hospital"; not an outpatient service at another location
2. Hospital is a **general acute care or chronic care hospital**
3. Service was **medically necessary**
4. Patient is a **Maryland resident** (regardless of immigration status)
5. For the 1/3rd of hospitals with **asset tests**, patient qualifies under the asset test
6. **Patient income**
   a. Under 200% FPL = free care
   b. Under 300% FPL = reduced cost care if the patient resides in the hospital's **service area**
   c. Under 500% FPL w/ financial hardship = reduced cost care if the patient resides in the hospital's **service area**

Source: Health-General §§ 19-201, 19-211, and 19–214.1, Maryland Code & COMAR 10.37.10.26

Other laws, including federal tax law related to charity care, may apply.

Recent Changes in Financial Assistance Law

Eligibility

- Changes to align with existing regulations:
  - Free care eligibility threshold increased from 150% to 200% FPL;[1]
  - Hospitals must provide free care to patients enrolled in certain social services programs[1]
  - Reduced cost care eligibility threshold changed to 201% FPL to 300% FPL.[1]
- Income can be calculated any time between the date of service and 240 days after the initial hospital bill.[2]
- A hospital may not consider citizenship or immigration status in determining eligibility.[1]
- Increased exclusions of assets from asset tests.[1] Hospitals are allowed, but not required to have asset tests.

2. Chapter 769, 2021

Recent Changes in Financial Assistance Law

Notice

- Addition of a space for patients to initial that they have received the financial assistance policy on the information sheet.[1,2] The information sheet is an existing requirement that provides information on debt collection and financial assistance. Hospitals must provide the information sheet to patients before a patient receives scheduled medical services, before discharge, with the hospital bill, on request, and in each written communication to the patient regarding collection of the hospital bill).
- Notice of the availability of financial assistance and the information sheet must be available in each language spoken by LEP populations that are at least 5% of population.[3]

1. Chapter 470, 2020
2. Chapter 769, 2021
3. Chapter 135, 2022

Recent Changes in Financial Assistance Law

Denials

- Hospitals must have a mechanism to allow a patient to request reconsideration of a denial.[1]

Reporting Requirements

- Each year, hospitals must submit financial assistance policies to the HSCRC and data on financial assistance applications and denials.[1]
- Financial assistance policies and this data is required to be posted on HSCRC's website.[1]
- HSCRC is required to submit the data to legislature.[1]

1. Chapter 470, 2020

Appendix: Medical Debt Collection Requirements

Medical Debt Collection Requirements

- Hospitals must have a medical debt collection policy that meets specified legal requirements and must submit that policy to HSCRC.
- Hospitals may not sell medical debt but may contract with debt collectors/collection agency, if the hospital supervises that organization.
- Hospitals must provide refunds to certain patients.
- Certain assets and income are protected from debt collection.

Source: Health-General § 19–214.2, Maryland Code & COMAR 10.37.10.26

Recent Changes in Medical Debt Collection Law

Income-based Payment Plans

- Previously payment plans were only required for patients between 200%-500% FPL. Now hospitals must offer income-based payment plans to all patients.
- The monthly payment amount due under income-based payment plans is limited to 5% of the patient's income.
- Patients must receive information about the availability of income-based payment plans multiple times.

Refunds

- Patients may be found eligible for financial assistance within 240 days after the initial bill, and thus eligible for refunds of paid amounts.

Source: Chapter 769, 2021

Recent Changes in Medical Debt Collection Law

Credit Reporting

- Adverse information may not be reported to a credit reporting agency until the 181st day after the initial patient bill.
- A hospital may not report adverse information to a credit reporting bureau-
  - for patients who are uninsured or eligible for financial assistance;
  - patients who requested reconsideration of a financial assistance denial;
  - for amounts subject to an insurance appeal, if the hospitals knows of the appeal.
- Credit reporting must be struck in certain situations.

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Source: Chapter 769, 2021

Recent Changes in Medical Debt Collection Law

Legal Action

- The law contains timelines for lawsuits to collect medical debt and includes situations where a lawsuit is prohibited for a period of time.
- Additional assets were added to the list of assets that are protected from collection for medical debt and some other legal remedies are limited.
- The hospital must send a notice to the patient before filing a legal action that contains specific content.
- Specific information must be included in the legal complaint that starts a lawsuit to collect medical debt.

*Regulations clarifying this legal requirement are expected in 2023.
Source: Chapter 769, 2021

Recent Changes in Medical Debt Collection Law

Reporting Requirements

- Hospitals must submit debt collection policies to the HSCRC annually.
  - Policies are posted on HSCRC's website
- Hospitals must submit data to the HSCRC on legal actions to collect date, patients with bad debt, and the amount of debt associate with patients with and without insurance.
- HSCRC must post these policies and data on their website.
- HSCRC must submit the data to the legislature.

Source: Chapter 709, 2021

Appendix: Enforcement

Enforcement: Medical Debt and Financial Assistance

- Enforcement is joint with the AG's office:
  - HSCRC can fine hospitals ("knowing" standard)
  - AG can take action under the Consumer Protection Act (Cease and desist order, Injunction, Action for Damages, Civil Penalty, Criminal Penalties (Misdemeanor))
- HSCRC's expertise is necessary to allow for effective enforcement:
  - Understanding of hospital finances and UCC
  - Auditing
  - Data

Source: Health-General § 19–214.3, Maryland Code

Original Text (from the regulations currently in effect) is in plain text.

Proposed changes to the regulation are in italics.

MARYLAND DEPARTMENT OF HEALTH

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 10 Rate Application and Approval Procedures

Authority: Health-General Article, §§19-207, 19-214.1 and 19-214.2, Annotated Code of Maryland

.26 Patient Rights and Obligations; Hospital Credit and Collection and Financial Assistance Policies.

A. Definitions. In this regulation, the following terms have the meanings indicated:

(1) Adjusted medical debt-"Adjusted medical debt" means medical debt, excluding co-payments, coinsurance, and deductibles.

(2) Credit and Collection Policy- "Credit and collection policy" means a hospital's policy on the collection of medical debt.

(3) Debt Collector.

(a) "Debt collector" means a person who engages directly or indirectly in the business of:

(i) Collecting for, or soliciting from another, medical debt;

(ii) Giving, selling, attempting to give or sell to another, or using, for collection of medical debt, a series or system of forms or letters that indicates directly or indirectly that a person other than the hospital is asserting the medical debt; or

(ii) Employing the services of an individual or business to solicit or sell a collection system to be used for collection of medical debt.

(b) "Debt collector" includes a 'collection agency,' as defined in Business Regulation Article, §7-101, Annotated Code of Maryland.

(4) Financial Hardship -"Financial hardship" means adjusted medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

(5) Gross monthly income - "Gross monthly income" means total monthly income, before taxes. A hospital may divide gross annual income by twelve to determine gross monthly income if the hospital has access to annual income information and not specific information on income in a recent month.

(6) Hospital - "Hospital" means a facility defined in Md. Code Ann., Health-Gen. § 19- 301(f).

(7) Income-Based Payment Plan - "Income-based payment plan" means a payment plan that meets the requirements of Health-General Article, §19-214.2(e)(3)(i), Annotated Code of Maryland, and §B-2(5) of this regulation.

(8) Initial Bill- "Initial bill" means the first billing statement provided to an individual by a hospital after the care, whether inpatient or outpatient, is provided and the individual has left the hospital facility.

(9) Medical Debt-"medical debt" means out-of-pocket expenses (including co-payments, coinsurance, and deductibles) for hospital services that are regulated by HSCRC and are billed by the hospital to a patient or a co-signer for the patient, excluding amounts contractually paid by another payer (e.g. insurers, Medicare, Medicaid, or CHIP).

(10)Medically Necessary Care- "Medically necessary care" means that the service or benefit is:

(a) Directly related to diagnostic, preventative, curative, palliative, rehabilitative or ameliorative treatment of an illness, injury, disability or health condition;

(b) Consistent with current accepted standards of good medical practice; and

(c) Not primarily for the convenience of the consumer, family or the provider.

(11)Non-Income-Based Payment Plan - "Non-income-based payment plan" means a payment plan that is not an income-based payment plan.
(12)Payment Plan - "Payment plan" means an agreement between a patient (or a guarantor) to pay for a hospital service over a period of time, including an income-based payment plan under§A(6) of this regulation and a non-income-based payment plan under §A(10) of this regulation.
(13) "Written" Communications.

(a) "Written" means communications in paper form and communications delivered electronically, including through electronic mail, a secure web, or mobile based application such as a patient portal.
(b) "Written" does not include oral communications, including communications delivered by phone.

A-2. Electronic Delivery of Written Communications

(1) A patient may opt out of receiving written communications required by this regulation through electronic delivery methods (such as through email or a patient portal).
(2) A hospital or debt collector who communicates with a patient electronically must include in such communication, or attempt to communicate, a clear and conspicuous statement describing a reasonable and simple method by which the patient can opt out of further electronic communications by the hospital or debt collector.
(3) A hospital or debt collector may not require, directly or indirectly, that the patient, in order to opt out of electronic communication, must pay any fee or provide any information other than the patient's opt out preferences and the email address, telephone number for text messages, or other electronic-medium address subject to the opt-out request.
(4) If a hospital or debt collector receives notice from a patient that the patient is opting out of receiving written communications through electronic delivery methods, the hospital or the debt collector-
(a) may not provide the written communications required by this regulation through electronic delivery methods; and
(b) must deliver the written communications through non-electronic delivery methods.
(5) (a) If a hospital receives notice from a patient that the patient is opting out of receiving written communications through electronic delivery methods, and the hospital uses a debt collector with respect to that patient, the hospital must immediately inform the debt collector that the patient is opting out of electronic delivery methods.
(b) If a debt collector receives notice from a patient that the patient is opting out of receiving written communications through electronic delivery methods, the debt collector must immediately inform the hospital that controls that patient account that the patient is opting out of electronic delivery methods.

B[A.**]** *B.* Hospital Information Sheet.

(1) Each hospital shall develop an information sheet that:

(a) Describes the hospital's financial assistance policy *as required in §B-3 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland*;

(b) Describes a patient's rights and obligations with regard to hospital billing and collection under the law;

(c) Provides contact information for the individual or office at the hospital that is available to assist the patient, the patient's family, or the patient's authorized representative in order to understand:

(i) The patient's hospital bill;

(ii) The patient's rights and obligations with regard to the hospital bill, including the patient's rights and obligations with regard to reduced-cost, medically necessary care due to a financial hardship;

(iii) How to apply for **[**free and reduced-cost care**]** *financial assistance*; **[**and**]**

(iv) How to apply for the Maryland Medical Assistance Program and any other programs that may help pay the bill; *and*

(v) How to apply for a payment plan;

(d) Provides contact information for the Maryland Medical Assistance Program;

(e) Includes a statement that physician charges, to both hospital inpatients and outpatients, are generally not included in the hospital bill and are billed separately;

(f) Informs patients that the hospital is permitted to bill outpatients a fee, commonly referred to as a "facility fee", for their use of hospital facilities, clinics, supplies and equipment, and nonphysician services, including but not limited to the services of nonphysician clinicians, in addition to physician fees billed for professional services provided in the hospital;

(g) *In addition to the good faith estimate requirements in the Public Health Service Act § 2799B-6, the No Surprises Act, i*[I]nforms patients of their right to request and receive a written estimate of the total charges for the hospital non-emergency services, procedures, and supplies that reasonably are expected to be provided and billed for by the hospital;

(h) Informs a patient or a patient's authorized representative of the right to file a complaint with the Commission or jointly with the Health Education and Advocacy Unit of the Maryland Attorney General's Office against a hospital for an alleged violation of Health-General Article, §§19-214.1 and 19-214.2, Annotated Code of Maryland, which relate to financial assistance and debt collection; and

(i) Provides the patient with the contact information for filing the complaint**[**.**]***;*

(j) Includes a section that allows the patient to initial that the patient has been made aware of the financial assistance policy; and

(k) Includes language explaining the availability of an income-based payment plan.

(2) The information sheet shall be in:

(a) Simplified language in at least *12*-point type; and

(b) The patient's preferred language or, if no preferred language is specified, each language spoken by a limited English proficient population that constitutes 5 percent of the overall population within the city or county in which the hospital is located as measured by the most recent census.

(3) The information sheet shall conform with Health-General Article, §19–342, Annotated Code of Maryland.

[(3)]*(4)* The information sheet shall be provided *in writing* to the patient, the patient's family, **[**or**]** the patient's authorized representative*, or the patient's legal guardian*:

(a) Before the patient receives scheduled medical services;

(b) Before discharge;

(c) With the hospital bill;

(d) On request; and

(e) In each written communication to the patient regarding collection of the hospital bill.

[(4)]*(5)* The hospital bill shall include a reference to the information sheet.

[(5)]*(6)* The Commission shall:

(a) Establish uniform requirements for the information sheet; and

(b) Review each hospital's implementation of and compliance with the requirements of this section.

[A-1.**]** *B-1.* Hospital Credit and Collection **[**Policies**]** *Responsibilities*.

(1) Each hospital shall submit to the Commission, at times prescribed by the Commission, the hospital's *credit and collection policy*.

(2) The policy shall:

(a)Prohibit the charging of interest on bills incurred by self-pay patients before a court judgment is obtained;

(b) Limits the charging of interest or fees on any medical debt to those patients the hospital determines are not eligible for free or reduced-cost care on or after the date of service under §B-3 of this regulation and Health-General Article, §19–214.1, Annotated Code of Maryland;

[(b)**]** *(c)Describe in detail the consideration by the hospital of patient income, assets, and other criteria;*

[(c)**]** *(d) Describe the hospital's procedures for collecting any medical debt;*

[(d)**]** *(e)Describe the circumstances in which the hospital will seek a judgment against a patient;*

[(e)**]** *(f)* Provide for a refund of amounts collected from a patient or the guarantor of a patient who was later found to be eligible for free care **[**on the date of service, in accordance §A-1(3) of this regulation**]***, in accordance*

with §B-3 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland, within 240 days after the initial bill was provided;

[(f)] *(g)* If the hospital**[**,**]** has obtained a judgment against or reported adverse information to a consumer reporting agency about a patient who later was found to be eligible for free *medically necessary* care **[**on the date of the service for which the judgment was awarded or the adverse information was reported**]**, *in accordance with §B-3 of this regulation and Health-General Article, §19-214.2, Annotated Code of Maryland, within 240 days after the initial bill was provided,* require the hospital to seek to **[**vacated**]** *vacate* the judgment or strike the adverse information;

[(g)] *(h)* Provide a mechanism for a patient to file with the hospital a complaint against the hospital or an outside collection agency used by the hospital regarding the handling of the patient's bill;

[(h)] *(i)* Provide detailed procedures for the following actions:

(i) When a patient*'s medical* debt may be reported to a credit reporting agency;

(ii) When legal action may commence regarding a patient*'s medical* debt;

(iii) When garnishments may be applied to a patient's or patient guarantor's income; and

(iv) When a lien on a patient's or patient guarantor's personal residence*, excluding a primary resident in accordance with §B-1(9)(b) of this regulation and Health-General Article, §19-214.2(g)(2), Annotated Code of Maryland,* or motor vehicle may be placed;

(j) Prohibit the hospital from collecting additional fees in an amount that exceeds the approved charge for the hospital service as established by the Commission for which medical debt is owed on a hospital bill for by a patient who is eligible for free or reduced-cost medically necessary care, in accordance with §B-3 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland; and

(k) Establish a process for making payment plans available to all patients in accordance with §B-2 of this regulation and Health-General Article, §19-214.2(e)(3), Annotated Code of Maryland.

(3) Consistent with Health-General Article, §19-214.2(e)(5), Annotated Code of Maryland, a hospital shall demonstrate that it attempted in good faith to meet the requirements of Health-General Article, §19-214.2(e), Annotated Code of Maryland and the Guidelines before the hospital:

(a) Files an action to collect the patient's medical debt; or

(b) Delegates collection activity to a debt collector for a patient's medical debt.

(4) The hospital shall be deemed to have demonstrated that it attempted to act in good faith under Health-General Article, §19-214.2(e)(5)(i)(2), Annotated Code of Maryland and §B-1(3)(b) of this regulation if, before delegating collection of a patient's medical debt to a debt collector, the hospital:

(a) Provides the information sheet before the patient receives scheduled medical services and before discharge in accordance with Health-General Article, §19-214.2(e)(1) and (2), Annotated Code of Maryland, and §B(4)(a) and (b) of this regulation; and

(b) Establishes a process for making payment plans available to all patients in accordance with Health-General Article, §19-214.2(e)(5), Annotated Code of Maryland, and §B-1(2)(k) of this regulation;

(5) In delegating any or all collection to a debt collector for a patient's medical debt, the hospital may rely on a debt collector to engage in various activities, including:

(a) Facilitating and servicing payment plans in accordance with the Guidelines, including receiving and forwarding any payments received under a payment plan approved by the hospital; and

(b) Such other activities as the hospital may direct in collecting and forwarding payments under a payment plan.

(6) A hospital may not seek legal action to collect a patient's medical debt until the hospital has established and implemented a payment plan policy that complies with the Guidelines.

[(3)**]** *(7)* Beginning October 1, 2010, as provided by Health-General Article, §19-214.2(c):

(a) A hospital shall provide for a refund of amounts exceeding $25 collected from a patient or the guarantor of a patient who, within a 2-year period after the date of service, was found to be eligible for free *medically necessary* care on the date of service;

(b) A hospital may reduce the 2-year period under §**[**A-1(3)(a)**]***B-1(7)(a)* of this regulation to no less than 30 days after the date the hospital requests information from a patient, or the guarantor of a patient, to determine the patient's eligibility for free *medically necessary* care at the time of service, if the hospital documents the lack of cooperation of the patient or the guarantor of a patient in providing the required information; and

(c) If a patient is enrolled in a means-tested government health care plan that requires the patient to pay out-of-pocket for hospital service, a hospital shall have a refund policy that complies with the terms of the patient's plan.

[(4)**]** *(d)* For at least **[**120**]** *180* days after issuing an initial **[**patient] bill, *a hospital may not*:

(i) **[**a hospital may not report**]** *Report* adverse information about a patient to a consumer reporting agency against a patient for nonpayment;

(ii) Commence a civil action against a patient for nonpayment; and

(iii) Give notice of civil action to a patient under §B-1(14) of this regulation and Health-General Article, §19-214.2(g)(3), Annotated Code of Maryland.

(e) A hospital may not report adverse information to a consumer reporting agency regarding a patient who, at the time of the service, was uninsured or eligible for free or reduced-cost medically necessary care, in accordance with §B-3 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland.

(f) A hospital may not report adverse information about a patient to a consumer reporting agency, commence civil action against a patient for nonpayment, or delegate collection activity to a debt collector, if the hospital:

(i) Was notified in accordance with federal law by the patient or the insurance carrier that an appeal or a review of a health insurance decision is pending within the immediately preceding 60 days; or

(ii) Has completed a requested reconsideration of the denial of free or reduced-cost medically necessary care under §B-3(1)(a)(ii)(E) of this regulation and Health-General Article, §19-214.1(b)(4), Annotated Code of Maryland, that was appropriately completed by the patient within the immediately preceding 60 days.

[(5)**]** *(8) Consumer Reporting.*

(*a*) A hospital shall report the fulfillment of a patient's payment obligation within 60 days after the obligation is fulfilled to any consumer reporting agency to which the hospital had reported adverse information about the patient.

(b) If a hospital has reported adverse information about a patient to a consumer reporting agency, the hospital shall instruct the consumer reporting agency to delete the adverse information about the patient:

(i) If the hospital was informed by the patient or the insurance carrier that an appeal or a review of a health insurance decision is pending, and until 60 days after the appeal is complete; or

(ii) Until 60 days after the hospital has completed a requested reconsideration of the denial of free or reduced-cost medically necessary care, in accordance with §B-3 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland.

[(6)**]** *(9) Primary Residences.*

(a) A hospital may not force the sale or foreclosure of a patient's primary residence to collect [a] *the medical* debt [owed on a hospital bill]. **[**If a hospital holds a lien on a patient's primary residence, the hospital may maintain its position as a secured creditor with respect to other creditors to whom the patient may owe a debt.**]**

(b) A hospital may not request a lien against a patient's primary residence in an action to collect medical debt.

(10) If the hospital files an action to collect medical debt, the hospital may not request the issuance of or otherwise knowingly take action that would cause a court to issue:

(a) A body attachment against a patient; or

(b) An arrest warrant against a patient.

(11) A hospital may not request a writ of garnishment of wages or file an action that would result in an attachment of wages against a patient to collect medical debt if the patient is eligible for free or reduced-cost medically necessary care, in accordance with §B-3 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland.

(*12) Deceased patients.*

(a) A hospital may not make a claim against the estate of a deceased patient to collect medical debt if the deceased patient was known by the hospital to be eligible for free medically necessary care, in accordance with §B-3 of this regulation and Health-General article, §19-214.1, Annotated Code of Maryland, or if the value of the estate after tax obligations are fulfilled is less than half of the medical debt owed.

(b) A hospital may offer the family of the deceased patient the ability to apply for financial assistance.

(13) A hospital may not file an action to collect medical debt until the hospital determines whether the patient is eligible for free or reduced-cost medically necessary care under §B-3 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland.

(14) At least 45 days before filing an action against a patient to collect medical debt, a hospital shall send written notice of the intent to file an action to the patient. The notice shall:

(a) Be sent to the patient by certified mail and first class mail;

(b) Be in simplified language and in at least 12-point type;

(c) Include:

(i) The name and telephone number of the hospital, the debt collector (if applicable), and an agent of the hospital authorized to modify the terms of the payment plan (if any);

(ii) The amount required to cure the nonpayment of medical debt, including past due payments, penalties, and fees;

(iii) A statement recommending that the patient seek debt counseling services;

(iv) Telephone numbers and internet addresses of the Health Education Advocacy Unit of the Office of the Attorney General, available to assist patients experiencing medical debt; and

(v) An explanation of the hospital's financial assistance policy;

(d) Be provided in the patient's preferred language or, if no preferred language is specified, English and each language spoken by a limited English proficient population that constitutes 5 percent of the population within the jurisdiction in which the hospital is located as measured by the most recent federal census; and

(e) Be accompanied by:

(i) An application for financial assistance under the hospital's financial assistance policy, along with instructions for completing the application for financial assistance, specific instructions about where to send the application, and the telephone number to call to confirm receipt of the application;

(ii) Language explaining the availability of a payment plan to satisfy the medical debt that is the subject of the hospital debt collection action; and

(iii) The information sheet required under §B of this regulation and Health-General Article, §19-214.1(f), Annotated Code of Maryland.

[(7)**]** *(15)* If a hospital delegates collection activity to **[**an outside collection agency**]** *a debt collector*, the hospital shall:

(a) Specify the collection activity to be performed by the **[**outside collection agency**]** *debt collector* through an explicit authorization or contract;

(b) Require the debt collector to abide by the hospital's credit and collection policy;

[(b)**]** *(c)* Specify procedures the **[**outside collection agency**]** *debt collector* must follow if a patient appears to qualify for financial assistance *under §B-3 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland;* and

[(c)**]** *(d)* Require the **[**outside collection agency**]** *debt collector* to:

(i) In accordance with the hospital's *credit and collection* policy, provide a mechanism for a patient to file with the hospital a complaint against the hospital or the **[**outside collection agency**]** *debt collector* regarding the handling of patient's bill; **[**and**]**

(ii) If a patient files a complaint with the **[**collection agency**]** *debt collector*, forward the complaint to the hospital; *and*

(iii) Along with the hospital, be jointly and severally responsible for meeting the requirements of §B-1 and §B-3 of this regulation and Health-General Article, §19-214.2, Annotated Code of Maryland.

(16) A spouse or another individual may not be held liable for the medical debt of an individual 18 years old or older unless the individual voluntarily consents to assume liability for the patient's medical debt. The consent shall be:

(a) Made on a separate document signed by the individual;

(b) Not solicited in an emergency room or during an emergency situation; and

(c) Not required as a condition of providing emergency or non-emergency health care services.

[(8)**]** *(17)* The Board of Directors of each hospital shall review and approve the financial assistance and *credit and collection* policies of the hospital every 2 years. A hospital may not alter its financial assistance or *credit and collection* policies without approval by the Board of Directors.

[(9)**]** *(18)* The Commission shall review each hospital's implementation of and compliance with the hospital's policy and the requirements of §**[**A-1(2)**]***B-1(2)* of this regulation.

(19) Reporting Requirements.

(a) Each hospital shall annually submit to the Commission within 120 days after the end of each hospital's fiscal year a report including:

(i) The total number of patients by race or ethnicity, gender, and zip code of residence against whom the hospital or a debt collector used by the hospital, filed an action to collect medical debt;

(ii) The total number of patients by race or ethnicity, gender, and zip code of residence with respect to whom the hospital has and has not reported or classified a bad debt; and

(iii) The total dollar amount of charges for hospital services provided to patients but not collected by the hospital for patients covered by insurance, including the out-of-pocket costs for patients covered by insurance, and patients without insurance.

(b) The Commission shall post the information submitted under §B-1(19)(a) of this regulation on its website.

B-2. Guidelines for Hospital Payment Plans.

(1) Scope.

(a) As described in this regulation, the Guidelines for Hospital Payment Plans apply to any payment plan offered by a hospital to a patient to pay for medically necessary hospital services after the services are provided.

(b) Prepayment Plans. Nothing in the Guidelines prevents a hospital from offering patients arrangements to make payments prior to service, provided that:

(i) A hospital may not require or steer a patient to enter into such an arrangement solely to avoid the application of these Guidelines;

(ii) before a hospital requests pre-payment for a hospital service, the hospital shall-

1. *comply with the notice provisions of Health General 19-214.1 and §B and §B-3 of this regulation;*
2. *advise the patient about the availability of financial assistance;*
3. *process any request for financial assistance; and*
4. *advise the patient about the availability of income-based payment plans, including information about the 5 percent cap on monthly payment amounts under §B-2(6)(a) of this regulation; and*

(ii) such an arrangement terminates once the hospital service is rendered.

(c) Unregulated Services. These Guidelines apply only to hospital services that are regulated by the HSCRC. These Guidelines do not apply to services that are not regulated by the HSCRC, including physician services.

(d) Limitation of the Guidelines. These Guidelines do not prevent hospitals from extending payment plans for services (such as physician services) or at times that are outside the parameters of the Guidelines. Except as otherwise required by law or regulation, payment plans that are outside the parameters of these Guidelines are not subject to the Guidelines.

(2) Access to Income-Based Payment Plans.

(a) Availability of Income-Based Payment Plans. Maryland hospitals shall make income-based payment plans available to all patients who are Maryland residents, including individuals temporarily residing in Maryland due to work or school, irrespective of their:

(i) Insurance status;

(ii) Citizenship status;

(iii) Immigration status; or

(iv) Eligibility for reduced-cost care, including reduced-cost care due to financial hardship, under this regulation.

(b) Treatment of Nonresidents and Unregulated Services.

(i) These Guidelines do not prevent a hospital from extending payment plans to patients who are not described in §B-2(2)(a) of this regulation.

(ii) These Guidelines do not prevent a hospital from extending payment plans to patients for services that are not regulated by the HSCRC.

(ii) Except as required by §B-2 (23) of this regulation or by other law or regulation, payment plans for patients who are not described in §B-2(2)(a) of this regulation and payment plans for services that are not regulated by the HSCRC are not subject to the Guidelines under §B-2 of this regulation.

(3) Notice Requirements.

(a) Notice of Availability of an Income-Based Payment Plan.

(i) Posted Notice.

1. *A notice shall be posted in conspicuous places throughout the hospital, including the billing office, informing Maryland residents of the availability of an income-based payment plan and whom to contact at the hospital for additional information.*
2. *If the hospital uses a vendor to assist with financial assistance eligibility, billing, or debt collection (such as a debt collector or eligibility vendor), the hospital shall ensure that the vendor posts a notice in a conspicuous place on their website or online payment portal, informing Maryland residents of the availability of an income-based payment plan and whom to contact at the hospital or debt collector for additional information. Placement on the website or online payment portal should be based on the best interest of the patient.*

(ii) Information Sheet. A written notice of the availability of an income-based payment plan shall be contained in the information sheet required under this regulation, including clarity on the availability of income-based payment plans for Maryland residents, and, if payment plans for non-residents are included in the hospital's credit and collection policy, the availability of such plans for non-residents.

(iii) Before a Prepayment Plan. Before a patient enters into a prepayment plan as described in §B-2(1)(b) of this regulation for a medically necessary hospital service, a hospital shall provide a written notice of the availability of an income-based payment plan to a patient.

(iv) On a Bill. On the same page of the bill that includes the amount due and due date, the hospital shall provide notice that a lower monthly payment amount may be possible through an income-based plan, in the same font and style as the total amount due notification.

(v) Online Payment Portal. On both the page of the online payment portal that states the amount due, and where the consumer enters the amount being paid by the consumer, the hospital shall provide, in the same font and style as the amount due notification, notice informing Maryland residents of the availability of an income-based monthly payment plan and information, including a telephone number and email address, in order to contact the hospital for additional information.

(b) Notice of Terms Before Execution. A hospital shall provide written notice of the terms of an income-based payment plan to a patient before the patient agrees to enter the income-based payment plan. The terms of the income-based payment plan shall include:

(i) The amount of medical debt owed to the hospital;

(ii) The interest rate applied to the income-based payment plan and the total amount of interest expected to be paid by the patient under the income-based payment plan;

(iii) The amount of each periodic payment expected from the patient under the income-based payment plan;

(iv) The number of periodic payments expected from the patient under the income-based payment plan;

(v) The expected due dates for each payment from the patient;

(vi) The expected date by which the account will be paid off in full;

(vii) The treatment of any missed payments, including missed payments and default as described in §B-2(18) and (22) of this regulation;

(viii) That there are no penalties for early payments; and

(ix) Whether the hospital plans to apply a periodic recalculation of monthly payment amounts as described in §B-2(17) of this regulation and the process for such recalculation;

(c) Notice of Plan After Execution. A hospital shall promptly provide a written income-based payment plan, including items listed in §B-2(3)(b) of this regulation, to the patient following execution by all parties. The income-based payment plan shall be provided to the patient at least 20 days before the due date of the patient's first payment under the income-based payment plan.

(4) Financial Assistance. Before entering into an income-based payment plan with a patient, a hospital shall evaluate if the patient is eligible for financial assistance, including free care, reduced-cost care, and reduced-cost care due to financial hardship, in accordance with this regulation. The hospital will apply the financial assistance reduction before entering into an income-based payment plan with a patient.

(5) Offer Required. Hospitals must offer income-based payment plans that meet the requirements of these Guidelines.

(6) Monthly Payment Amounts.

(a) Under an income-based payment plan subject to these Guidelines, a hospital may not require a patient to make total payments in a month that exceed 5 percent of the lesser of the individual patient's federal or State adjusted gross monthly income.

(b) Paragraph (a) applies to total amounts due under the plan, including both principal and interest, but does not apply to any catch-up payments, such as payments described under section B-2(18)(a) of this regulation.

(7) Calculation of Income. A hospital shall calculate a patient's income for purposes of determining the monthly payment amount under §B-2(6)(a) of this regulation by taking the following steps:

(a) Determining the Income Amount.

(i)If the patient provided their tax returns, the hospital may determine the patient's gross monthly income using the information from the tax return.

(ii) If the patient has not provided their tax returns, the hospital shall use available information, including information provided by the patient, to approximate the patient's adjusted gross income.

(iii) Income that is not taxable, such as certain gifts, may not be treated as income for purposes of determining the income limitation under this guideline.

(b) Determining the Number of Filers and Dependents. The hospital shall determine the number of tax filers and dependents listed on the tax return provided by the patient. For example, if a married couple files jointly and has three dependents, the number of tax filers and dependents would equal five. If a patient files as an individual and the patient is not a dependent and has no dependents, the number of tax filers would equal one. If the patient has not provided a tax return, the hospital shall ask the patient to provide the number of tax filers and dependents.

(c) Determining the Patient's Pro-Rata Share of Income. The hospital shall divide the income amount determined under §B-2(7)(a) of this regulation by the number of tax filers and dependents under §B-2(7)(b) of this regulation. This is the individual patient's income for purposes of determining the 5 percent limit on the income-based payment plans under the Guidelines.

(8) Income Documentation.

(a) Hospitals shall accept generally acceptable forms of documentation that verify income, such as tax returns, pay stubs, and W2s.

(b) Hospitals may accept patient attestation of the patient's monthly or annual income and the number of filers and dependents on their tax return without documentation. Such an attestation shall include the patient's income and the number of filers and dependents on their tax return. If the patient provides an attestation of income the hospital is not required to conduct any additional income verification.

(9) Expenses. A hospital shall consider information provided by a patient about household expenses in determining the amount of the monthly payment due under an income-based payment plan.

(10) Application to Multiple Income-based Payment Plans.

(i) Hospitals. A hospital shall ensure that the total monthly payment amount for all income-based payment plans provided to a patient by the hospital, when added up collectively, does not exceed the income limitation under §B-2(6)(a) of this regulation.

(ii) Hospital System. A hospital system shall ensure that the total monthly payment amount for all income-based payment plans provided to a patient by all hospitals in the hospital system, when added up collectively, does not exceed the income limitation under §B-2(6)(a) of this regulation.

(11) Duration of Income-Based Payment Plan. The duration of an income-based payment plan, in months, is determined by the total amount owed (and interest, if interest applies) divided by the total amount of the payment due each month, subject to the limitation that no monthly payment may exceed 5 percent of the patient's income as calculated under §B-2(6)(a) of this regulation.

(12) Solicitation of Early Payments Prohibited. Hospitals may not solicit, steer, or mandate patients to pay an amount in excess of the monthly payment amount provided for in an income-based payment plan.

(13) Application of Partial Payments. A hospital shall apply partial payments in a manner most favorable to the patient.

(14) Interest and Fees.

(a) No Interest for Patients Eligible for Financial Assistance. A hospital shall limit the charging of interest or fees on any medical debt amount owed under an income-based payment plan to those patients the hospital determines are not eligible for free or reduced-cost care on or after the date of service under §B-3 of this regulation and Health-General Article, §19–214.1, Annotated Code of Maryland;

(b) No Interest for Self-Pay Patients. A hospital may not charge interest on bills incurred by self-pay patients in an income-based payment plan.

(c) Interest Allowed. A hospital may charge interest under an income-based payment plan for a patient who is not described in §B-2(14)(a) and (b) of this regulation. A hospital is not required to charge interest for a payment plan.

(d) Interest Rate. An income-based payment plan may not provide for interest in excess of an effective rate of simple interest of 6 percent per annum on the unpaid principal balance of the payment plan. A hospital may not set an interest rate that results in negative amortization.

(e) Timing. Interest may not begin before 180 days after the due date of the first payment.

(f) Late payments. A hospital may not charge additional fees or interest for late payments.

(15) Early Payment.

(a) Prepayment Allowed.

(i) Patients may, on a voluntary basis, pre-pay, in whole or in part, any amounts owed under an income-based payment plan.

(ii) Any prepayment made under §B-2(15)(a) is not subject to the monthly income payment limitations of §B-2(6)(a) of this regulation.

(b) No Fees or Penalties. A hospital may not assess fees or otherwise penalize early payment of an income-based payment plan.

(16) Limited Modifications of Income-based Payment Plans.

(a) Change in Income. If a patient with an income-based payment plan notifies a hospital that the patient's income has changed then the hospital shall offer to modify the income-based payment plan to meet the requirement of §.26B-2(16)(f)(i)-(iv) of this regulation.

(b) Expenses. Before modifying an income-based payment plan, a hospital shall consider information provided by a patient about changes in household expenses in considering a patient request to modify a payment plan.

(c) No Increase in Interest Rate. A hospital may not increase the interest rate on an income-based payment plan when making a modification to an income-based payment plan under this guideline.

(d) Limitation on Payment Amount. A hospital may not modify an income-based payment plan in a way that requires a patient to make a monthly payment that exceeds the percent of the patient's income used to set the monthly payment amount under the initial income-based payment plan as provided for in §B-2(7) of this regulation.

(e) Change in Duration. The duration of a modified income-based payment plan, in months, is determined by the total amount owed (and interest, if interest applies) divided by the total amount of the payment due each month, subject to the limitation under §B-2(6) of this regulation.

(f) Process for Modifying a Payment Plan.

(i) Prompt Response to Patient Request. If a patient requests a modification to the terms of the payment plan, the hospital shall respond in a timely manner and may not refer the outstanding balance owed to a collection agency or for legal action until 30 days after providing a written response to the patient's request for a modification of the payment plan.

(ii) Reconsideration for Financial Assistance. If a patient makes a request for modification of a payment plan, the hospital shall consider if such patient is eligible for financial assistance, including free care, reduced-cost care, and reduced-cost care due to financial hardship under this regulation. The hospital will apply the financial assistance reduction in its modification of the payment plan.

(iii) Mutual Agreement. A hospital may not modify a payment plan without mutual agreement between the hospital and the patient before the changes are made.

(iv) Notice of Terms. The hospital shall provide the patient with a written notice of all payment plan terms, consistent with the requirements of §B-2(3) of this regulation, upon modifying a payment plan under this guideline.

(17) Hospital-Initiated Changes to Income-Based Payment Plans Based on Changes to Patient Income.

(a) Recalculation Allowed. A hospital may, in the terms of an initial income-based payment plan under §B-2 of this regulation that exceeds 3 years in length, provide for periodic recalculations to the amount of the monthly payments and the duration of the payment plan based on changes in the patient's income as subject to and calculated under §.26B-2(16)(e) of this regulation.

(b) Notice Included in Initial Income-Based Payment Plan. The hospital may only recalculate payment amounts under an income-based payment plan if the hospital included the process for such recalculation in the notice provided to the patient before they entered into the income-based payment plan, in accordance with §B-2(3)(b) of this regulation. The patient's agreement to enter into the income-based payment plan after receiving that notice constitutes consent to the payment recalculations allowed under §B-2(17) of this regulation.

(c) Limitations on Modification Apply. The provisions of §B-2(16) of this regulation relating to limitations of payment plan modifications apply to payment recalculations for income-based payment plans under §B-2(17) of this regulation.

(d) Frequency of Recalculation. A hospital may not seek a recalculation of the monthly payment amount under an income-based payment plan, as provided for under this §B-2(17)(a) of this regulation more often than once every 3 years.

(e) Treatment of Missing Information. If a patient does not provide income information on the request of the hospital seeking to make a change to an income-based payment plan under §B-2(17) of this regulation and the patient is in good standing on the patient's payments under the income-based payment plan, the hospital may not change the monthly payment amounts under the income-based payment plan.

(18) Treatment of Missed Payments.

(a) First Missed Payment.

(i) A hospital may not deem a patient to be noncompliant with an income-based payment plan if the patient makes at least 11 scheduled monthly payments within a 12-month period.

(ii) Subject to §B-2(18)(a)(iii) of this regulation, the hospital shall permit the patient to repay the missed payment amount at any time, as determined by the patient, including through a set of partial payments.

(iii) No later than 30 days after the first missed payment in a 12-month period, the hospital shall notify the patient of the missed payment and inform the patient that the patient may be in default if they do not pay the amount of the missed payment within 12 months or if they miss additional payments within the 12-month period. The notice will give the patient the option to pay the missed payment by paying the amount of the missed payments in one of the following ways:

A. 11 increments over the subsequent 11 months;

B. a single payment; or

C. Another approach, as specified by the patient.

(iv) With respect to a patient that has missed a single monthly payment in a 12-month period, the hospital shall provide the patient with a method to designate whether any amount of a payment paid in the subsequent 12-month period is to be applied to the amount of missed payment or applied in a different manner.

(v) With respect to a patient that has missed a single monthly payment in a 12-month period, if the hospital receives a payment and the patient has not designated how that payment is to be applied, the hospital shall first apply the amount to any payment that is due in the 31-day period following the date the payment is received. If there is no payment due in the next month, the hospital shall apply the amount of the payment to the missed payment. If the amount of the payment exceeds the amount of any payment that is due in the 31-day period following the date the payment is received, the excess amount shall be applied to the missed payment.

(vi) The hospital may consider a patient to be in default on the income-based payment plan if the missed payment is not repaid in full by the end of the 12-month period that begins on the date of the missed payment under §B-2(18)(a) of this regulation.

(b) Additional Missed Payments.

(i) A hospital may forbear the amount of any additional missed payments that occur in a 12-month period.

(ii) If a hospital forbears the amount of any additional missed payments that occur in a 12-month period, the hospital shall allow the patient to continue to participate in the income-based payment plan.

(iii) If a hospital forbears the amount of any additional missed payments that occur in a 12-month period, the hospital may not refer the outstanding balance owed to a collection agency or for legal action.

(iv) The hospital shall recapitalize the amount of any missed payments that were subject to forbearance under this §B-2(18) of this regulation as additional payments at the end of the income-based payment plan, thereby extending the length of the income-based payment plan.

(v) The hospital shall provide written notice to the patient of the treatment of the missed payments, including any extension of the length of the income-based payment plan.

(19) Treatment of Loans and Extension of Credit. After a hospital service is provided to the patient, a hospital, hospital affiliate, or third-party in partnership with a hospital may not make any loan or extension of credit to the patient in connection with a medically necessary hospital service that is inconsistent with the guidelines for payment plans in §B-2 of this regulation resulting from that service.

(20) Application of Credit Provisions of Maryland Commercial Law Article and Licensing Provisions of Financial Institutions Article. An income-based payment plan is an extension of credit subject to Maryland credit regulations under Commercial Law Article, Title 12, Annotated Code of Maryland and any applicable licensing provisions of Financial Institutions Article, Title 11, Annotated Code of Maryland.

(21) Books and Records. A hospital shall retain books and records on income-based payment plans for at least 3 years after the income-based payment plan is closed.

(22) Default.

(i)If a patient defaults on an income-based payment plan and the parties are not able to agree to a modification, then the hospital shall follow the provisions of its credit and collection policy established in accordance with this regulation, before a hospital may write this medical debt off as bad debt.

(ii) With respect to the amounts covered by the income-based payment plans, a patient who is on an income-based payment plan and is not in default on that payment plan shall not be considered in arrears on their debt to the hospital when the hospital is making decisions about scheduling health care services.

(23) Non-Income-Based Payment Plans.

(a) Other Payment Plans Allowed. A hospital may offer a non-income-based payment plan under these guidelines, but must first offer the patient an income-based payment plan.

(b) Application of Guidelines: Consistent with the guidelines for hospital payment plans and consistent with the intent of Health General 19-214.2, the following provisions of this regulation apply to non-income-based payment plans in the same manner such provisions apply to income-based payment plans:

- *(i) §B-2(1) of this regulation, regarding scope;*
- *(ii) §B-2(2)of this regulation, regarding access to payment plans;*
- *(iii) §B-2(3)(b) of this regulation, regarding notice of payment plan terms before execution;*
- *(iv) §B-2(3)(c) of this regulation, regarding notice of plan after execution;*
- *(v) §B-2(4) of this regulation, regarding financial assistance;*
- *(vi) §B-2(14) of this regulation, regarding interest and fees;*
- *(vii) §B-2(15)(a)(i) and §B-2(15)(b) of this regulation, regarding early payments;*
- *(viii) §B-2(16)(f)(i)-(iv) of this regulation, regarding modifications of payment plans;*
- *(ix) §B-2(19) of this regulation, relating to treatment of loans and extensions of credit;*
- *(x) §B-2(20) of this regulation, relating to the application of credit provisions of Maryland Commercial Law Article and the licensing provisions of Financial Institutions Article;*
- *(xi) §B-2(21) of this regulation, relating to books and records; and*
- *(xii) §B-2(22) of this regulation, relating to default.*

(c) Notice

(i) Notice of Terms Before Execution: In addition to complying with the terms of §B-2(3)(b), the hospital must include notice that the patient may apply for an income-based payment plan at any time in the notice of terms before execution of a non-income-based payment plan.

(ii) Notice of Plan After Execution: The hospital must include the notice required in §B-2(23)(c)(i) of this regulation in the notice of the payment plan after execution that is required by §B-2(3)(c) of this regulation.

(iii) Notice with Bills: Each bill for a non-income-based payment plan shall include a notice that informs the patient that income-based payment plans are available, which could result in lower monthly payments and provides information on how to apply for such plans.

(d) Consent. Before entering into a non-income-based repayment plan with a patient, the hospital must obtain consent from the patient that records that the patient agrees to the following:

(i) The hospital offered the patient an income-based payment plan.

(ii) The income-based payment plan limits monthly payment amounts to 5 percent of the patient's monthly income.

(iii) The income-based payment plan may result in lower monthly payment amounts than the monthly payment amounts under the non-income-based repayment plan.

(iv) The patient has the opportunity to disclose their income and determine the payment amount under the income-based payment plan.

(v) The patient is declining to enter an income-based payment plan and is consenting to enter a non-income-based repayment plan.

(e) Modification of a Non-Income-Based Payment Plan: In addition to complying with the terms of §B-2(16)(f)(i)-(iv) of this regulation, before modifying a non-income-based payment plan-

(i) the hospital shall offer the patient an income-based payment plan; and,

(ii) if the patient declines the income-based payment plan, obtain the consent required under §B-2(23)(d) of this regulation.

(f) Default.

(i) If the patient defaults on a non-income-based payment plan, the hospital must offer an income-based payment plan to the patient before the hospital follows the provisions of its credit and collection policy to collect the debt.

(ii) The offer under B-2(23)(f)(i) must be sent separately from a bill.

(24) Steering:

(a) A hospital may not steer patients to non-income-based payment plans, or third-party credit providers, in such a manner that discourages patients from entering into income-based payment plans.

(b) A hospital may not steer patients to revolving credit products in such a manner that discourages patients from entering into either income-based payment plans or non-income based payment plans under section B-2 of this regulation.

[A-2.**]** *B-3.* Hospital Financial Assistance Responsibilities.

(1)**[**Definitions

(a) In this regulation, the following terms have the meanings indicated.

(b) Terms Defined.

(i) "Financial hardship" means medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

(ii) "Medical debt" means out-of-pocket expenses, excluding copayments, coinsurance, and deductibles, for medical costs billed by a hospital.**]**

[(2)**]** Financial Assistance Policy.

(a) (*i*)On or before June 1, 2009, each hospital and on or before October 1, 2010, each chronic care hospital under the jurisdiction of the Commission shall develop a written financial assistance policy for providing free and reduced-cost *medically necessary* care to low-income patients who lack health care coverage or to patients whose health insurance does not pay the full cost of the hospital bill. A hospital shall provide *written* notice of the hospital's financial assistance policy to the patient, the patient's family, or the patient's authorized representative before discharging the patient and in each communication to the patient regarding collection of the hospital bill.

(ii) The financial assistance policy shall provide at a minimum:

(A) [(i)] Free medically necessary care to patients with family income at or below 200 percent of the federal poverty level;

(B) [(ii)] Reduced-cost**[**,**]** medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level, in accordance with the mission and service area of the hospital;

(C) (iii) A maximum patient payment for reduced-cost *medically necessary* care not to exceed the charges minus the hospital mark-up;

(D) [(iv)] A payment plan available to *all* patients **[**irrespective of their insurance status with family income between 200 and 500 percent of the federal poverty level who request assistance**]** *in accordance with the Guidelines*; and

(E) [(v)] A mechanism for a patient, irrespective of that patient's insurance status, to request the hospital to reconsider the denial of free or **[**reduced**]** *reduced-cost medically necessary* care, including the address, phone number, facsimile number, email address, mailing address, and website of the Health Education and Advocacy Unit, which can assist the patient or patient's authorized representative in filing and mediating a reconsideration request.

(iii) The hospital shall provide free and reduced cost medically necessary care to all qualified Maryland residents, regardless of their immigration status.

(iv) The hospital shall provide free medically necessary care under §B-3(1)(a)(ii)(A) of this regulation to all qualified Maryland residents, regardless of whether the patient resides in the hospital's service area.

(iv) If the hospital only provides reduced cost care to patients from the hospital's service area, the hospital shall provide a clear description of this geographic restriction in the hospital's financial assistance policy.

(v) The financial assistance policy applies to all medically necessary hospital services. Hospitals may not exclude non-urgent or elective, but medically necessary, care from their financial assistance policy.

(b) The financial assistance policy shall calculate a patient's eligibility for free medically necessary care under §B-3(1)(a)(ii)(A) of this regulation and Health-General Article, §19-214.1(b)(2)(i), Annotated Code of Maryland or reduced-cost medically necessary care under §B-3(1)(a)(ii)(B) of this regulation and Health-General Article, §19-214.1(b)(2)(ii), Annotated Code of Maryland at the date of service or updated, as appropriate, to account for any change in the financial circumstances of the patient that occurs within 240 days after the initial bill is provided.

[(b) A hospital whose financial assistance policy as of May 8, 2009, provides for free or reduced-cost medical care to a patient at an income threshold higher than those set forth above may not reduce that income threshold.**]**

(c) Presumptive Eligibility for Free *Medically Necessary* Care. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the following means-tested social services programs are deemed eligible for free *medically necessary* care**[**, provided that the patient submits proof of enrollment within 30 days unless the patient or the patient's representative requests an additional 30 days**]**:

(i) Households with children in the free or reduced lunch program;

(ii) Supplemental Nutritional Assistance Program (SNAP);

(iii) Low-income-household energy assistance program;

(iv) Primary Adult Care Program (PAC), until such time as inpatient benefits are added to the PAC benefit package;

(v) Women, Infants and Children (WIC); or

(vi) Other means-tested social services programs deemed eligible for hospital free *medically necessary* care policies by the Maryland Department of Health and the HSCRC, consistent with **[**HSCRC regulation COMAR 10.37.10.26**]** *this regulation*.

(d) *If a*[A] hospital that believes that an increase to the income thresholds as set forth above may result in undue financial hardship, [to] it may file a written request with the Commission that it be exempted from the increased threshold. In evaluating the hospital's request for exemption, the Commission shall consider the hospital's:

(i) Patient mix;

(ii) Financial condition;

(iii) Level of bad debt experienced;

(iv) Amount of *[*charity care*]financial assistance* provided; and

(v) Other relevant factors.

(e) Based on staff's evaluation of the written request for an exemption, the Executive Director shall respond in writing within a reasonable period of time approving or disapproving the hospital's exemption request.

(f) A hospital denied an exemption request shall be afforded an opportunity to address the Commission at a public meeting on its request. Based on arguments made at the public meeting, the Commission may approve, disapprove, or modify the Executive Director's decision on the exemption request.

[(3)**]** *(2)* Each hospital shall submit to the Commission within **[**60**]** *120* days after the end of each hospital's fiscal year:

(a) The hospital's financial assistance policy developed under this section; and

(b) An annual report on the hospital's financial assistance policy that includes:

(i) The total number of patients who completed or partially completed an application for financial assistance during the prior year;

(ii) The total number of inpatients and outpatients who received free *medically necessary* care during the immediately preceding year and reduced-cost *medically necessary* care for the prior year;

(iii) The total number of patients who received financial assistance during the immediately preceding year, by race or ethnicity and gender;

(iv) The total number of patients who were denied financial assistance during the immediately preceding year, by race or ethnicity and gender;

(v) The total cost of hospital services provided to patients who received free *medically necessary* care; and

(vi) The **[**total cost**]** *total cost* of hospital services provided to patients who received reduced-cost *medically necessary* care that was covered by the hospital as financial assistance or that the hospital charged to the patient.

(3) Financial Hardship Policy.

(a) Subject to §**[**A-2(b) and (c)**]***B-2(3)(b)* of this regulation, the financial assistance policy required under *§B-3 of this regulation and Health-General Article, §19-214.1, Annotated Code of Maryland,* shall provide reduced-

cost**[**,**]** medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship.

(b) A hospital may seek, and the Commission may approve a family income threshold that is different than the family income threshold under §**[**A-2(c)(1)**]** *B-3(3)(a)* of this regulation.

(c) In evaluating a hospital's request to establish a different family income threshold, the Commission shall take into account:

(i) The median family income in the hospital's service area;

(ii) The patient mix of the hospital;

(iii) The financial condition of the hospital;

(iv) The level of bad debt experienced by the hospital:

(v) The amount of the *[*charity care*] financial assistance* provided by the hospital; and

(vi) Other relevant factors.

(d) If a patient has received reduced-cost **[**,**]** medically necessary care due to a financial hardship, the patient or any immediate family member of the patient living in the same household:

(i) Shall remain eligible for reduced-cost **[**,**]** medically necessary care when seeking subsequent care at the same hospital during the 12-month period beginning on the date on which the reduced-cost **[**,**]** medically necessary care was initially received; and

(ii) To avoid an unnecessary duplication of the hospital's determination of eligibility for free and reduced-cost care, shall inform the hospital of the patient's or family member's eligibility for the reduced-cost **[**,**]** medically necessary care.

[(5)**]** *(4)* If a patient is eligible for reduced-cost medical*ly necessary* care under a hospital's financial assistance policy or financial hardship policy, the hospital shall apply the reduction in charges that is most favorable to the patient.

[(6)**]** *(5)*

(i) A notice shall be posted in conspicuous places throughout the hospital including the billing office informing patients of their right to apply for financial assistance and who to contact at the hospital for additional information.

(ii) *If the hospital uses a vendor to assist with financial assistance eligibility, billing, or debt collection (such as a debt collector or eligibility vendor), that vendor shall post a notice in a conspicuous place on their website or online payment portal, informing patients of their right to apply for financial assistance, providing a link to the financial assistance application, and providing information on how to submit the application. Placement on the website or online payment portal should be based on the best interest of the patient.*

[(7)**]** *(6)* The notice required under §**[**A-2(6)**]***B-3(5)* of this regulation shall be in:

(a) Simplified language in at least 10-point type; and

(b) The patient's preferred language or, if no preferred language is specified, each language spoken by a limited English proficient population that constitutes 5 percent of the overall population within the city or county in which the hospital is located as measured by the most recent census.

[(8)**]** *(7)* Each hospital shall use a [Uniform] Financial Assistance Application in the manner prescribed by the Commission in order to determine eligibility for free and reduced-cost *medically necessary* care.

(8) Each hospital shall use a Financial Assistance Application that meets the requirements of this regulation and is consistent with the Uniform Financial Assistance Application.

(9) Each hospital shall establish a mechanism to provide *a* [the Uniform] Financial Assistance Application to patients regardless of their insurance status. A hospital may require from patients or their guardians only those documents required to validate the information provided on the application.

10) Asset Test Requirements. A hospital may, in its discretion, consider household monetary assets in determining eligibility for financial assistance in addition to the income-based criteria, or it may choose to use only income-based criteria. If a hospital chooses to utilize an asset test, the following types of monetary assets, which are those assets that are convertible to cash, shall be excluded:

(a) At a minimum, the first $10,000 of monetary assets;

(b) A "safe harbor" equity of $150,000 in a primary residence;

(c) Retirement assets to which the Internal Revenue Service has granted preferential tax treatment as a retirement account, including, but not limited to, deferred-compensation plans qualified under the Internal Revenue Code or nonqualified deferred-compensation plans;

(d) One motor vehicle used for the transportation needs of the patient or any family member of the patient;

(e) Any resources excluded in determining financial eligibility under the Medical Assistance Program under the Social Security Act; and

(f) Prepaid higher education funds in a Maryland 529 Program account.

(11) Monetary assets excluded from the determination of eligibility for free and reduced-cost *medically necessary* care under these provisions shall be adjusted annually for inflation in accordance with the Consumer Price Index.

(12) In determining the family income of a patient, a hospital shall apply a definition of household size that consists of the patient and, at a minimum, the following individuals:

(a) A spouse, regardless of whether the patient and spouse expect to file a joint federal or State tax return;

(b) Biological children, adopted children, or stepchildren; and

(c) Anyone for whom the patient claims a personal exemption in a federal or State tax return.

(13) For a patient who is a child, the household size shall consist of the child and the following individuals:

(a) Biological parents, adoptive parents, stepparents, or guardians;

(b) Biological siblings, adopted siblings, or *step siblings*[stepsiblings]; and

(c) Anyone for whom the patient's parents or guardians claim a personal exemption in a federal or State tax return.

[A-3.**]** *B-4.* Patient Complaints. The Commission shall post a process on its website for a patient or a patient's authorized representative to file with the Commission a complaint against a hospital for an alleged violation of Health-General Article, §19-214.1 or 19-214.2, Annotated Code of Maryland. The process established shall include the option for a patient or a patient's authorized representative to file the complaint jointly with the Commission and the Health Education and Advocacy Unit. The process shall conform to the requirements of Health-General Article, §19-214.3, Annotated Code of Maryland.

[B.**]** *C.* Working Capital Differentials — Payment of Charges.

(1) A third-party payer may obtain a discount in rates established by the Commission if it provides current financing monies in accordance with the following terms.

(a) A third-party payer that provides current financing equal to the average amount of outstanding charges for bills from the end of each regular billing period and for discharged patients shall be entitled to a 2-percent discount. For purposes of this regulation, a regular billing period shall be based on a 30-day billing cycle. The current financing provided [in here] *to hospitals* corresponds to a third party's paying on discharge.

(b) A third-party payer that provides current financing equal to the average amount of outstanding charges for discharged patients plus the average daily charges times the average length of stay, shall be entitled to a 2.25-percent discount. The current financing provided [in here] *to hospitals* corresponds to a third party's paying on admission.

(c) Outstanding charges shall be calculated by an amount equal to the hospital's current average daily payment by the payer, multiplied by the hospital's and third party payer's processing and payment time. The precise calculation shall be made in accordance with the guidelines specified by Commission staff.

(d) Upon request from an applicant, the Commission may approve an alternative method of calculating current financing monies.

(e) The third-party payer shall adjust the current financing advance to reflect Commission rate orders and changes in volume associated with the particular payer and hospital. This adjustment shall be made within 45 days of a rate order or at such other time as circumstances warrant. In the absence of a rate order, the adjustment shall be made at least annually.

(2) The third-party payer shall promptly provide the Commission with a verified record of the detailed calculation of the current financing and of each recalculated balance as adjustments are made. The detailed calculations shall become a part of the public record. The Commission may, at any time, evaluate the amount of current financing monies provided to a hospital to assure that it meets the discount of requirements specified in §**[**B**]***C*(1) of this regulation. If the Commission finds that the amount of current financing is inconsistent with the requirements of §[B]*C*(1), the Commission may, at its sole discretion, require an adjustment to the working capital advance or to the discount.

(3) A payer or self-paying patient, who does not provide current financing under §**[**B**]***C*(1)(a)—(e) of this regulation, shall receive a 2-percent discount if payment is made at the earlier of the end of each regular billing period or upon discharge from the hospital. Payment within 30 days of the earlier of the end of each regular billing period or discharge entitles a payer or self-pay patient to a 1-percent discount. For those payers not subject to Insurance Article, §15-1005, Annotated Code of Maryland, after 60 days from the date of the earlier of the end of each regular billing period or discharge, interest or late payment charges may accrue on any unpaid charges at a simple rate of 1 percent per month. The interest or late payment charges may be added to the charge on the 61st day after the date of the earlier of the end of each regular billing period or discharge and every 30 days after that. *For patients that have entered into a hospital income-based payment plan, the interest rate shall be established in accordance with the Guidelines.*

(4) Hospital Billing Responsibilities.

(a) A patient shall be given a bill for services at the earlier of the end of each regular billing period or upon discharge or dismissal (when dismissal for outpatients is analogous to discharge for inpatients).

(b) This bill shall cover substantially all care rendered and should, except for some last day ancillary services and excepting arithmetic errors, represent the full charge for the patient's care. In addition, a notice shall be posted prominently at the billing office of the hospital clearly notifying all patients of the availability of the discounts mentioned above.

(c) The bill and the notice shall state that the:

(i) Charge is due within 60 days of discharge or dismissal;

(ii) Patient shall receive a 2-percent discount by paying upon discharge or a 1-percent discount by paying within 30 days; and

(iii) Payers not subject to Insurance Article, §15-1005, Annotated Code of Maryland, may be subject to interest or late payment charges at a rate of 1 percent per month beginning on the 61st day after the date of the earlier of the end of each regular billing period or discharge and every 30 days after that.

(5) Hospital Written Estimate.

(a) *In addition to the good faith estimate requirements in PHS Act Sec. 2799B-6, the No Surprises Act,* on request of a patient made before or during treatment, a hospital shall provide to the patient a written estimate of the total charges for the hospital services, procedures, and supplies that reasonably are expected to be provided and billed to the patient by the hospital.

(b) The written estimate shall state clearly that it is only an estimate and actual charges could vary.

(c) A hospital may restrict the availability of a written estimate to normal business office hours.

(d) The provisions set forth in §**[**B**]***C*(5)(a)—(c) of this regulation do not apply to emergency services.

[C.**]** *D.* GME Discounts. In those instances where a teaching hospital is reimbursed separately for the costs associated with the provision of graduate medical education (GME), the Commission shall calculate the percentage of the hospital's rates that these GME payments represent and provide notice of the amounts that may be credited toward the payment for services rendered. At all times, total payment received by the teaching hospital shall be in accordance with Commission-approved rates.

E. Other Obligations. This regulation shall not diminish any obligations of a debt collector under other applicable laws or regulations, including, without limitation, any requirement for the debt collector to obtain a collection agency license from the State Collection Agency Licensing Board in accordance with Business Regulation Article, Title 7, subtitle 3 Annotated Code of Maryland.

maryland
health services
cost review commission

Commentary on Public Comments on Financial Assistance and Medical Debt Regulations

September 2023

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Introduction

This document contains comments received from the public on draft changes to COMAR 10.37.10.26, the Health Services Cost Review Commission's regulations on "Patient Rights and Obligations; Hospital Credit and Collection and Financial Assistance Policies" and HSCRC staff responses to those comments. This document includes the following:

1. comments received during the formal public comment period for the proposed regulation in 2022 (referred to in this document as "formal comments");
2. comments on either the 2022 proposed regulation, the law, or HSCRC's proposed 2023 legislation that were received after the 2022 public comment period closed; and
3. comments on the revised draft regulations that were shared with stakeholders in 2023.

This document contains direct quotes from the comment letters received during the formal public comment period in 2022. For the "informal comments" (items 2 and 3 above) in this document, some are direct quotes from written materials (letters, emails, etc.), while others are paraphrased from comments in meetings, rather than written comments. In all cases each comment is followed by a staff response to the comment.

This document is organized with broad policy topics first, followed by comments in the order of the corresponding regulatory provisions.

Impact on UCC

Formal Comment: *Johns Hopkins Health System*:

The payment plan policies outlined under HB 565 have the unintended consequence of increasing uncompensated care without appropriately distinguishing between those who need financial assistance and those who do not. Increased uncompensated care for those who simply choose not to pay, or to delay payment could impact the success of the Maryland Model.

New Jersey's previous all-payer system offers crucial insight into the potential consequences of

the addition of inappropriate uncompensated care costs to the model. As increasing uncompensated care costs were added to the New Jersey model, the model became unsustainable. An analysis of the New Jersey system demonstrated that "the presence of uncompensated care trust funds may discourage the purchase of private insurance," as care was provided to the uninsured at no cost. Additionally, because patients were not accountable for hospital-based care costs, "the uninsured used higher-cost hospital-based services rather than lower-cost community-based care." The experience in New Jersey illustrates that this policy may incent individuals to opt out of insurance to avoid a large medical bill, or drive patients to

seek routine care in hospitals, as there would be limited concern about a hospital bill. While well-intentioned, this policy undermines the objectives the model aims to achieve.

The HSCRC requires that hospitals make a "reasonable collection effort" before writing charges off to bad debt. These efforts are necessary to preserve usage of the uncompensated care fund for patients who are eligible for financial assistance. Additionally, federal regulations at 26 CFR § 1.501(r) require hospitals to engage in presumptive eligibility screening and notify the patient of available financial assistance prior to engaging in certain collection activities.

Response: Health General 19-214.2 requires income-based payment plans. HSCRC's regulatory changes are intended to follow the law. HSCRC's requirement of reasonable collection efforts continues, subject to legal and regulatory requirements, including Health General 19-214.2. It is important to note that financial assistance (and bad debt) are reported to the HSCRC as uncompensated care (UCC) and those amounts are built into hospital rates in a subsequent year.

Informal Comment: *Maryland Hospital Association*

Increased Cost-sharing as a Result of High-deductible Private Health Plans Invites Additional Uncompensated Care.

Most patients requiring hospital payment plans are individuals covered by private health plans with high deductibles. High-deductible private health plans shift significant out-of-pocket costs to patients. Accordingly, increased cost-sharing between private health insurance carriers and patients who may not have the means to pay for out-of-pocket costs invites additional uncompensated care in Maryland. While HSCRC does not regulate health plans, we encourage HSCRC, the Maryland Insurance Administration, and other stakeholders to assess the root cause of higher consumer cost sharing.

Response: HSCRC does not regulate commercial health plans and cannot address this issue in these regulations.

Direct Incorporation of Guidelines into Regulations

Formal Comment: *Maryland Hospital Association*

The direct incorporation of the payment plan guidelines into the regulations was not referenced in earlier versions. ….MHA strongly urges HSCRC staff to remove proposed section 10.37.10.26B-2 and return to the original draft for incorporation by reference. The Guidelines were drafted in the style of agency guidance, with the intent that HSCRC could expeditiously update them—within the parameters of Health-General § 19-214.2—based on feedback from stakeholders and consumers.

Formal Comment: *Ascension St. Agnes*

At this meeting, HSCRC staff's accompanying documents indicated that the payment guidelines would be incorporated by reference only within the regulations. Incorporating them by reference would allow the Guidelines to be updated more regularly based on feedback from implementation. The change to codify the payment guidelines directly into the regulations creates unnecessary hurdles if modifications or updates to the Guidelines are needed for any reason. Given the newness of both the regulations and changing technologies in the hospital self service patient portals, Ascension Saint Agnes strongly urges HSCRC to remove proposed section 10.37.10.26B-2 and return to the structure of incorporating the original draft by reference only. We appreciate HSCRC's continued dedication to hospitals and their patients. Thank you for your consideration of this recommendation.

Response*:* The HSCRC intended to incorporate the Guidelines by reference in the proposed regulations. However, there is a minimum of 50 pages, double-spaced, before a document can be incorporated by reference, and the Guidelines did not meet this standard. As a result, HSCRC placed the Guidelines within the regulations themselves. Either way, the Guidelines are considered regulations and, as such, are subject to the rules associated with the regulation promulgation, proposal, and adoption process.

Application to non-Maryland Residents

Informal Comment: *Mid-Atlantic Collectors Association*

If an individual seeks and obtains care in a Maryland hospital but is not a Maryland resident, which of these provisions apply?

Response: These regulations relate to Health General §§ 19-214.1 and 19-214.2, Maryland Code, which HSCRC interprets as applying to Maryland residents. With limited exceptions, these regulations do not speak to other applicable state or federal laws, which may apply to individuals who are not Maryland residents.

"Later Found to Be"

Informal Comment: *Mid-Atlantic Collectors Association*

"Is found to be." Throughout the revised regulation there are a number of areas in which specific activities are to occur if a patient is "**later found to be**" eligible for free or reduced-cost care." MACA respectfully requests that the phrase "is later found to be" be inserted before the phrasing "eligible for free or reduced-cost care" throughout all of the provisions of the regulation.

Response: In some cases, due to the clarity of the statutory language, HSCRC does not have the authority to make the requested changes. HSCRC has made changes to B-1(2)(b) and B-2(14)(a) of the regulation to address this concern.

Intersection with Internal Revenue Code

Informal Comment: *Mid-Atlantic Collectors Association*

Intersection or overlap with Internal Revenue Code §501r.

In many significant instances the regulation includes subject matter that could potentially conflict with or overlap requirements under Internal Revenue Code §501r. If and as that changes over time and controls if and how non profit hospitals manage their debt collection agencies – wouldn't it make more sense for Maryland's regulation to invoke those §501r requirements so that Maryland's regulation would keep pace with any changes?

Response: Maryland has had higher and more specific standards for hospital financial assistance and medical debt collection for more than a decade. The General Assembly was clear in their actions in 2009, 2010 and 2021 of their intention to set standards for the regulation of medical debt. This appears to be a concern with the statute, not with the regulations, and, as such, is not one that HSCRC can resolve.

EMTALA

Informal Comment: *Mid-Atlantic Collectors Association*

Would it be sensible for the regulations to invoke and synchronize to EMTALA versus potentially overlap it?

Response: HSCRC staff doesn't understand this comment. EMTALA requires screening, treatment, and stabilization of patients in emergency departments. This regulation relates to financial protections for patients. These are different issues.

"Adverse Action," Equal Credit Opportunity Act, and the Fair Credit Reporting Act

Informal Comment: *Mid-Atlantic Collectors Association*

In regard to actions hospitals may take on applications for financial assistance and the denial and reconsideration processes mapped in the proposed regulation, it appears that depending upon the mechanics potentially a hospital may be obligated to follow the adverse action requirements under the Equal Credit Opportunity Act (Regulation B) and/or the Fair Credit Reporting Act (Regulation V). Clarification is requested on how hospitals would synchronize potential responsibilities under

Regulation B and Regulation V and what the consequences would be if it were determined that income-based payment programs resulted in a disparate impact. To the extent that hospitals are now expected to calculate and/or verify income and assets in subsection 5 at page 9, we have the same or similar FCRA and ECOA concerns. In addition, given the detail on the hospital underwriting processes and account servicing standards articulated in the new detail (from paragraph 5 on page 9 through paragraph 20), must hospitals obtain licensing as credit grantors and/or small dollar or installment lenders to operate in the State of Maryland (see #20) and must they then comply with all of the requirements for a credit grantor under Maryland law?

Response: To the extent hospital payment plans are subject to FCRA or ECOA, that is a matter of federal law. This regulation does not create hospital payment plans, which already exist in Maryland, but rather outlines requirements for income-based repayment plans mandated by statute. Any conflict between federal and state law should be resolved by the legislative or judicial branches. This cannot be fixed in regulation. Whether a hospital requires a Maryland lending license will depend on factors within the hospital's control. Maryland law generally affords credit grantors an ability to elect the governing subtitle for an extension of credit and this election impacts licensing requirements. Hospitals must review Maryland lending laws in the context of their repayment programs and seek legal counsel. To the extent statutory law requires a hospital to obtain a lending license based on that hospital's lending policies, this regulation cannot remove that requirement.

A.(6): Define "Hospital" to Align with the Internal Revenue Code

Formal Comment: *Health Education and Advocacy Unit:* The amendment below would add a new definition in order to conform the proposed regulation to federal law and to fully effectuate remedial intent:

> Amendment, new .26A(*)
>
> "Hospital" means a facility defined in Md. Code Ann., Health-Gen. § 19- 301(f) and a substantially-related entity defined in 26 CFR § 1.501(r)-1(b)(28).

This definition corrects current inconsistencies with federal law in the proposed regulation which ignores substantially-related entities. 26 CFR § 1.501(r)– 4(b)(1)(i) requires a hospital's FAP to "[a]pply to all emergency and other medically necessary care provided by the hospital facility, including all such care provided in the hospital facility by a substantially-related entity (as defined in § 1.501(r)–1(b)(28))." Combined, the amended definitions of hospital and medical debt include amounts billed by hospitals and substantially-related entities for the purposes of FAP eligibility and the payment plans, in compliance with federal law. Because financial hardship eligibility (FHE) in Maryland is based on income and the amount owed, and it is foreseeable that the incomes of some payment plan participants will decrease or the amount

owed will increase, charges by substantially-related entities must be included to preserve their potential FHE.

Informal Comment: *Health Education and Advocacy Unit*

Federal law requires a hospital's financial assistance policies to "[a]pply to all emergency and other medically necessary care provided by the hospital facility, including all such care provided in the hospital facility by a substantially-related entity (as defined in § 1.501(r)–1(b)(28))." 26 CFR § 1.501(r)– 4(b)(1)(i). Because the financial assistance policies must also apply to substantially-related entities, the definition of hospital in .26B-3 (Hospital Financial Assistance Responsibilities) must include the substantially-related entities. The HEAU proposes that .26B-3 be amended to include the following definition for hospital:

"Hospital" means a facility defined in Md. Code Ann., Health-Gen. § 19- 301(f) and a substantially-related entity defined in 26 CFR §1.501(r)-1(b)(28).

This definition corrects current inconsistencies with federal law in the proposed regulation, which ignores substantially-related entities.

Response*:* HSCRC has included a definition of hospital that cross references Health General §19-301, Maryland Code. HSCRC has not included "substantially related entity" as HSCRC only regulates facilities that are licensed as hospitals in Maryland. Federal law applies to substantially-related entities.

A.(7) Income-Based Payment Plan Definition

Formal Comment: Health Education and Advocacy Unit

The definition should be amended to reference Health General § 19- 214.2(e), not just (e)(3), and to reference § B-2 of the regulation, not just § B-2(5).

Response: Health General § 19-214.2(e) contains paragraphs that are not about payment plans. The requirement to establish guidelines for income-based payment plans is in 19-214.2(e)(3)(i) and HSCRC staff feel that cross reference is the most accurate. Given the placement of § B-2(23) relating to non-income based payment plans within § B-2 of the regulation, it would be inappropriate to cite to all of § B-2. § B-2(5), the requirement on hospitals to offer income-based payment plans, is a clear and effective cross-reference.

A.(8): Definition of "Initial Bill" and Prepayment

Formal Comment: *Health Education and Advocacy Unit:*

We would also ask the Commission to amend .26A(4) to provide:

"Initial bill" means the first billing statement provided to an individual by a hospital after the care, whether inpatient or outpatient, is provided and the individual has left the hospital facility, and the basis for a payment, other than a copayment, made before care is provided.

Response: HSCRC has not changed this definition, as we do not feel that this is the appropriate place to address this policy concern. HSCRC clarified the rules related to prepayment in section B-2(1)(b)(ii) to address these concerns.

A.(9): Medical Debt and Out-of-Pocket Expenses

Informal Comment: What does the phrase "out-of-pocket expenses" mean in the definition of "medical debt"?

Response: This phrase was added to the financial assistance statute in 2010 (Ch. 60). It is not defined in the HSCRC's statute or regulations. HSCRC added a clarifying parenthetical to provide examples of the meaning of this term.

A.(4) and A(9): Define "Medical Debt" and "Financial Hardship" to Align with the FAP and Debt Collection Statutes and Conform to Federal Law

Formal Comment: *Health Education and Advocacy Unit:* "Medical debt" is not defined in the debt collection statute, but the term is used a few times in the statute, including in Md. Code Ann., Health-Gen. § 19-214.2(e)(3)(i), which requires the payment plan to include "the amount of medical debt owed to the hospital." Below, we recommend an amended definition that aligns with the debt collection statute because the proposed definition of "medical debt" does not. The proposed definition is identical to the definition in the financial assistance policies statute, Md. Code Ann., Health-Gen. § 19-214.1(a)(3)("FAP"), but the definition of medical debt in that statute is expressly limited to that statute, and is intended for the narrow purpose of defining "financial hardship" as a basis for reduced-cost care, Md. Code Ann., Health-Gen. § 19-214.1(a)(1) and (2). Importing the narrow definition from the financial assistance policies statute into the proposed regulation, which is also implementing the debt collection statute, undermines the purpose of the debt collection statute.

To fulfill the purpose of the statutory scheme established by the General Assembly, we ask the Commission for these amendments:

Amended .26A(5)

"Medical debt" means an amount owed by a patient to a hospital for hospital services.

Amended .26A(2)

"Financial hardship" means medical debt, excluding co-payments, coinsurance, and deductibles, incurred by a family over a 12-month period that exceeds 25 percent of family income.

These amendments fulfill both the intent of the FAP statute to exclude copayments, coinsurance, and deductibles from the medical debt amount used to determine financial hardship eligibility, and the remedial intent of the new payment plan scheme in the debt collection statute to allow affordable payments for uninsured and underinsured consumers who face unaffordable hospital bills.

Response*:* HG §19-214.1 defines "medical debt" narrowly, to exclude co-payments, coinsurance, and deductibles. HSCRC staff reviewed the use of the statutory definition of "medical debt" in HG §19-214.1. This term is used in the statute only for the purposes of determining eligibility for financial assistance on the basis of financial hardship. Applying this narrow definition to medical debt collection would limit protections for consumers, which is not aligned with the intent of the amendments made to HG §19-214.2 by Chapter 769 (2021).

The revised version of COMAR 10.37.10.26 now includes two definitions:

1. "adjusted medical debt", which is the same as the definition of "medical debt" in HG §19-214.1, and which applies only to the the determination of eligibility for financial assistance due to financial hardship; and
2. "medical debt", which does not exclude cost-sharing amounts for insured patients and thus is more protective for patients. This definition applies to hospital debt collection and payment plans.

The definition to "financial assistance" was not changed because the commenter's concern was addressed through the definitions above.

Informal Comment: Health Education and Advocacy Unit

The definition should say "including copayment, coinsurance and deductibles so as not to exclude balance billing."

Response: HSCRC staff changed "e.g." to "including" in response to this comment in the definition of "medical debt" in A.(9) of the regulation.

Informal Comment: *Health Education and Advocacy Unit*

The HEAU is concerned that the proposed definition of "Medical debt" includes too many qualifiers and potential loopholes and could undermine the intent of the statute to bring clarity to the collection of hospital debt and ensure that consumers who are eligible for financial assistance are not subject to debt collection.

Accordingly, the HEAU continues to believe that a more general definition of "Medical debt" is warranted. The HEAU suggests this definition:

"Medical debt" means out-of-pocket expenses for medical costs billed by a hospital.

Further, the HEAU believes the proposal to include only services that are regulated by the Commission is contrary to the language in the statute and not supported by the remedial nature of the financial assistance, debt collection, and payment plan policies intended to protect consumers from unaffordable hospital bills. While the Commission's rate setting jurisdiction is limited to "hospital services," that limitation does not apply to the financial assistance policy provisions, which require financial assistance policies for acute and chronic care hospitals under the Commission's jurisdiction, not just the services of that hospital that are rate-regulated. In the language of the statute, the financial assistance policy must apply to patients whose "health care coverage does not pay the full cost of the hospital bill." Md. Code Ann., Health Gen. § 19-214.1(b)(1) (emphasis added). Thus, the statute makes it clear that the financial assistance policies are intended to provide free and reduced-cost care to patients based on the full cost of the hospital bill, not just bills for rate-regulated services. The rate-setting limitation similarly does not apply to hospital debt collection practices and payment plan policies, which address amounts billed by hospitals and collected by hospitals, not just amounts billed and collected for rate-regulated services.

Response: HSCRC interprets Health General §§ 19-214.1 and 19-214.2 in the context of all of subtitle 2 of title 19 of the Health General Article of the Maryland Code, HSCRC's authorizing statute. Health General § 19-211 specifies the Commission's jurisdiction. Subsection (a) of Health General § 19-211 is not limited to rate setting. Section § 19-211 must be read in conjunction with the definitions in section § 19-201. Combined, these sections limit HSCRC's authority to hospital services, which are defined as inpatient services, emergency department services, and outpatient services "at a hospital" (Health General § 19-201(e)(1)).

A.(10) Define "Medically Necessary Services" to align with the FAP and Debt Collection Statutes and conform to Federal Law

Formal Comment: *Health Education and Advocacy Unit*

We ask the Commission to add a new definition for "medically necessary services." The term is not used in the debt collection statute but is used throughout the proposed regulations and in the FAP statute. "Medically Necessary" is a defined term in the IRS final rule governing FAP programs for charitable hospitals. 26 C.F.R. § 1.501(r)–5(e) allows, but does not require, a hospital's FAP to use one of several possible definitions, including the State's Medicaid definition. Our proposed amendment is derived from Maryland's Medicaid definition, contained in COMAR 10.67.01.01B(112).

Amendment, new .26A(*)

"Medically necessary care" means care that is:

(i) Directly related to diagnostic, preventative, curative, palliative, rehabilitative or ameliorative treatment of an illness, injury, disability or health condition;

(ii) Consistent with current accepted standards of good medical practice; and

(iii) Not primarily for the convenience of the consumer, their family or the provider.

Informal Comment: *Health Education and Advocacy Unit*

The HEAU appreciates the addition of a definition for "medically necessary services." As we previously commented, "medically necessary" is a defined term in the IRS final rule governing financial assistance programs ("FAP") for charitable hospitals. 26 C.F.R. § 1.501(r)–5(e) allows, but does not require, a hospital's FAP to use one of several possible definitions, including the State's Medicaid definition. Our earlier proposed amendment was derived from Maryland's Medicaid definition but removed one provision that could pose an unnecessary and unintended barrier to the remedial nature of the statutory scheme. As drafted, the definition would be:

"Medically necessary care" means that the service or benefit is:

Directly related to diagnostic, preventative, curative, palliative, rehabilitative or ameliorative treatment of an illness, injury, disability or health condition;

Consistent with current accepted standards of good medical practice;

The most cost-efficient service that can be provided without sacrificing effectiveness or access to care; and

Not primarily for the convenience of the consumer, family or the provider.

COMAR 10.09.92.01B(20)(italics added).

The Medicaid definition includes a benefit-related provision that is unnecessary in this context. Hospitals should not be given the opportunity to argue that the services provided weren't the most cost-efficient service in order to avoid providing financial assistance to consumers, especially since the care provided is the result of medical judgment. It would stand the statute on its head to permit hospitals to exempt from their financial assistance policies bills for services that the hospital now claims were not cost-effective services. The HEAU seeks a definition that does not include the language in COMAR 10.09.92.01B(20)(c).

Response*:* HSCRC agrees that the highlighted language could be used in ways that are counter to the purpose of this law. In addition, HSCRC does not feel that the financial assistance and medical debt collection regulations are the best place to address hospital efficiency. Hospital efficiency is addressed more directly and appropriately through HSCRC's payment methodologies, payment incentives, and under

hospital GBRs, including HSCRC's integrated efficiency policy. HSCRC changed this definition in response to the comment.

A-2. Electronic Delivery of Written Communications

Informal Comment: *Mid-Atlantic Collectors Association*

In .26.A-2, a provision has been inserted to facilitate electronic delivery of written communications. We respectfully request that in the event a patient who has opted into electronic communications wishes to opt out, any expression or change of communication preferences be provided in written, including electronic form, **not orally** to assure that the patient's communication preferences are understood, documented and recorded. Companies maintaining online resources are expected to take steps to assure those resources are ADA compliant and accessible. Many also host "IVR" or "interactive voice response" resources that can convert text-to-speech or speech-to-text to accommodate individuals with visual challenges. In addition, it is hoped that the final regulations will be flexible enough to allow hospitals and their debt collectors to harness artificial intelligence and other emerging technologies to accommodate all consumers regardless of how they prefer to communicate (while creating and maintaining documentation of consumers' preferences).

Informal Comment: *Medical Debt Coalition*

The opt-out process needs to allow for accessibility for people who are blind.

Response: HSCRC has made changes to this language to address concerns about the interaction with this language and regulation F. The new language does not state the format (oral, written, other) of the communication from the patient. This should allow hospitals to develop processes that work from a compliance perspective while also following applicable law about accessibility (including the ADA).

B. Information Sheet- Standardized Disclosure

Informal Comment: *Mid-Atlantic Collectors Association*

We like the idea of a standardized disclosure about this, that debt collectors would include in communications and would welcome some sample language for reference. Connecticut has such language that is included in debt collection letters.

Response: Hospitals have been required to provide information sheets to patients for a long time- this regulation is simply adding to the content that must be included in that information sheet. HSCRC does not plan to specify the language for those documents. Debt collectors should get the information sheet from the hospital that they work with.

B. Information Sheet- Accessibility

Formal Comment: *American Council of the Blind, Maryland & Marylanders for Patient Rights:*

1. It is of vital importance that information on payment plans and financial assistance be provided to patients in an accessible manner that the patient understands. For this reason, I propose that the regulation include language that is consistent with the Maryland Code 19-342 Hospital Patient's Bill of Rights:

> "The patient shall receive information in a manner that is understandable by the patient, which may include: (1) Sign and foreign language interpreters; (2) Alternative formats, including large print, braille, audio recordings, computer files; and (3) Vision, speech hearing and other temporary aids without charge."

This language should be included under the section "Hospital Information Sheet" to ensure accessibility.

2. The regulation should include a non-discrimination clause consistent with Maryland Code 19-342 Hospital Patient's Bill of Rights, to ensure health care equity in providing information on payment plans and assistance.

> "The patient should be provided information without discrimination based on race, color, national origin, ethnicity, age, gender, sexual orientation, gender identity or expression, physical or mental disability, religion, language, or ability to pay."

This language should also be included under the section "Hospital Information Sheet." Maryland needs to take every opportunity to reinforce the importance of health care equity for all.

Thank you for considering these comments.

Response*:* The Commission believes that Health-General Article, §19–342, Annotated Code of Maryland applies to the Information Sheet without need to restate the requirements of the Hospital Patient's Bill of Rights in these regulations. However, given the importance of this issue, the Commission has added a cross reference to the Hospital Patient's Bill of Rights in the portion of the regulation related to the information sheet. This approach also allows for any future changes to the Hospital Patient's Bill of rights to automatically be incorporated into these regulations.

B.(1)(a) Information Sheet- Notice of Financial Assistance

Informal Comment: *Mid-Atlantic Collectors Association*

Potentially a disclosure in collections communications? As is the case in Connecticut?

Response: The information sheet contains notice of the availability of financial assistance and it is required to be provided to patients with the hospital bill and in each written communication to the patient regarding collection of the hospital bill. Without further explanation, HSCRC doesn't see a need for any changes in the regulation in response to this comment.

B.(1)(c): Availability of Hospital Staff

Formal Comment: *Health Education and Advocacy Unit:* Proposed amendment to .26B(1)

(c) Provides contact information for the individual or office at the hospital that is readily available to assist the patient, the patient's family, or the patient's authorized representative in order to understand [how to apply for financial assistance and a payment plan, among other things]. Reason: The HEAU has received an influx of complaints from consumers unable to reach anyone at hospital financial assistance offices, along with complaints they receive no responses to their voicemail messages if they are able to leave messages.

Response*:* HSCRC does not believe that the suggested change will solve the issue raised in this comment. This is better addressed through oversight activities.

B.(1)(g) Reference to No Surprises Act

Formal Comment: *Health Education and Advocacy Unit*

Proposed amendment to .26B(1)(g) "In addition to the good faith estimate requirements in PHS Act Sec. 2799B-6, the No Surprises Act, (text unchanged)."

Reason: This long-standing provision about estimates requires updating with a reference to the No Surprises Act, which is in effect. PHS Act Sec. 2799B-6 of the No Surprises Act requires hospitals to provide pretreatment estimates when an individual schedules an item or service at least three business days in advance. Providers and facilities must, within one business day of the date of scheduling, ask about the individual's insurance coverage status and whether the individual is seeking to have a claim submitted to the individual's plan or coverage, and provide a good-faith estimate of the expected charges to the plan or issuer or to the individual if they are not insured or are not seeking to have a claim submitted to their plan or coverage. If the individual schedules the item or service at least 10 business days in advance, the provider or facility must meet these requirements within three business days of the date of scheduling. Though the provisions are temporarily delayed for patients using insurance, we do not want the proposed regulation to suggest that the NSA provisions do not apply.

Response: HSCRC made this change.

B.(1)(k): Inclusion of Payment Plan information in the Information Sheet

Formal Comment: *Maryland Hospital Association:* Proposed .26B(1)(c)(v) and (k) requires hospitals to put language about the availability of payment plans in the patient information sheet. At the HSCRC Hospital Payment Plan Guidelines Work Group, hospitals urged HSCRC to retain flexibility so hospitals can identify the most meaningful way to notify patients of available payment plans. Many hospitals may decide to follow the course of action stipulated in proposed language, but other options must be allowed to prevent confusion between patient financial assistance eligibility and payment plan availability.

Formal Comment: *Johns Hopkins Health System:* HB 565 requires hospitals to include information about the availability of payment plans to patients at the following times: before the patient is discharged; within the hospital bill; upon request; and in each written communication to the patient regarding collection of hospital debt. The proposed regulations stipulate how this information must be provided. We recommend that the HSCRC grant hospitals the flexibility to comply with this statutory requirement in the most efficient manner for their patients, whether as part of the medical bill, on the information sheet, or as an electronic notice. For JHHS, this information is already readily available. Information on payment plans is available online, during phone calls, posted through the facilities and on every statement.

Response: Commission staff considered this feedback from hospitals during the workgroup on the Guidelines on income-based payment plans and determined that the Information Sheet, as authorized by law, was the appropriate document for the required notice of payment plans.

B-1.(1): Hospital Credit and Collection Policies and Federal Law

Informal Comment: *Mid-Atlantic Collectors Association*

Because this is an area of the regulation that overlaps both with Internal Revenue Code Section § 501r and in some instances potentially the Fair Credit Reporting Act (insofar as it describes methods or assets or information to be considered in evaluating whether or not a patient may qualify for financial assistance) potential guidance or a model “hospital credit and collection policy” would be helpful both to consumers and industry as it would present a consistent, predictable resource or baseline for conducting collections.

Response: Hospitals have been required, by law, to have debt collection policies since 2009. Each hospital has its own policy and should provide it to any debt collector or other vendor who assists the hospital in the collection of debts. The hospital must “Provide for active oversight by the hospital of any contract for collection of debts on behalf of the hospital” under that policy, Health General 19-214.2(b)(1).

B-1.(2)(g) Vacating Judgments and Striking Credit Information

Formal Comment: *Health Education and Advocacy Unit:*

Proposed Amendment. .26B-1(2)

> (g) If the hospital[,] has obtained a judgment against or reported adverse information to a consumer reporting agency about a patient who later was found to be eligible for free medically necessary care [on the date of the service for which the judgment was awarded or the adverse information was reported], in accordance with §B-2 of this regulation and Health-General Article, §19-214.2, Annotated Code of Maryland, within 240 days after the initial bill was provided, require the hospital to seek to [vacated] vacate the judgment [or] and strike the adverse information, as applicable;

Reason: In the event both are needed, "and" is necessary.

Response*:* Health General 19-214.2 uses "or". HSCRC is simply following the statute in this language.

B-1.(2)(i) Procedures for Commencing Legal Action

Informal Comment: *Health Education and Advocacy Unit*

B-1(2)(i) – if hospitals are engaging in collection activities of any kind, the consumer should know this information.

Response: Hospital debt collection policies are public documents, but are not written for consumers. Overloading the consumer with information is not effective and could prevent them from understanding the information that is most important. HSCRC staff think it is better to focus on providing patients with the most important information.

Informal Comment: *Mid-Atlantic Collectors Association*

Hospitals in Maryland do not likely themselves resort to legal means to collect – so are the provisions relating to legal collections meant to apply to any vendor retained by those hospitals, including legal counsel or other debt collection professionals, and if so – might a "uniform" or other standard set of provisions for managing those vendors make sense?

Response: Health General 19-214.2 requires that hospitals have policies on the collection of debts that describe the circumstances in which a hospital will seek a judgment against a patient and provide for active oversight of debt collectors working for the hospital to ensure they comply with that policy. COMAR contains similar language. Hospitals continue to have the obligation to follow their debt collection policies and supervise debt collector actions to ensure that they meet the standards in law for filing legal actions to collect debt.

B-1.(3) and (4): Good Faith Provision and Debt Collection

Formal Comment: *Maryland Hospital Association:* Proposed .26B-1(4) defines when a hospital is "deemed to have acted in good faith" before filing an action for medical debt or delegating collection activities to a debt collector. This clarification has no basis in the statute and should be struck.

Formal Comment: *Health Education and Advocacy Unit:* Strike .26B-1(4) because it negates the remedial prerequisite of a hospital's good faith compliance with the payment plan scheme prior to traditional debt collection. Before filing a debt collection action or delegating collection activity to a debt collector, a hospital "shall demonstrate that it attempted in good faith to meet the requirements of" the debt collection statute and the Guidelines, Md. Code Ann., Health-Gen. § 19-214.2(e). To ensure compliance with this statutory good faith requirement, the Commission and the Consumer Protection Division should have full use of their authority to develop and consider a factual record in its entirety. It is inappropriate to constrain the statutory requirement of good faith so narrowly in a regulation, particularly a regulation stating that good faith consists of handing out an information sheet and having a developed payment plan process; such actions amount to minimum efforts and would fail to fully meet compliance with the statutory requirements on their face. We urge the Commission to strike proposed .26B-1(4).

Informal Comment: *Health Education and Advocacy Unit*

Before filing a debt collection action or delegating collection activity to a debt collector, a hospital "shall demonstrate that it attempted in good faith to meet the requirements of" the debt collection statute and the guidelines. Md. Code Ann., Health-Gen. § 19-214.2(e). To ensure compliance with this statutory good faith requirement, the Commission and the Consumer Protection Division should have full use of their authority to develop and consider a factual record in its entirety.

The HEAU objects to and urges the Commission to strike .26B-1(4), which, as drafted, appears to eviscerate the statutory requirement and is entirely inconsistent with the remedial intent of the governing legislation. Indeed, it appears to bless some hospitals' current practice of providing simple notice about consumer protections but creating undue barriers that prevent consumers from availing themselves of the protections.

It is contrary to the statute as passed by the General Assembly and inappropriate and inconsistent with the intent of the statute to constrain the statutory requirement of good faith so narrowly in a regulation, particularly a regulation stating that a statutory good faith requirement is deemed to be met by merely handing out an information sheet and developing a payment plan process; such actions amount to minimum efforts and do not by themselves establish that the hospital has acted in good faith. Indeed, a hospital that does not seek to facilitate a consumer's access to payment plans is not acting in good faith.

Response: HSCRC has addressed this concern by adding the following phrase "to have demonstrated that it attempted" to comply with this provision of the regulation.

HSCRC believes that it is important to ensure that regulated entities have clarity about what they need to do to comply with the law, particularly regarding the implementation of a complex regulation like this one. Health General 19-214.2 prohibits a hospital from delegating collection activity to a collection agency unless the hospital can demonstrate good faith compliance with the law. The law also renders the debt collector jointly and severally responsible for hospital's compliance with applicable law. The combination of these two provisions potentially impacts the willingness of any debt collector to accept indebtedness from a hospital.

As drafted, the regulation creates a safe harbor solely for the purpose of allowing the hospital to delegate collection activity. Specifically, it does not create a safe harbor for the hospital initiating legal action against a debtor or for any other action the hospital may have taken. It serves solely to provide measurable, verifiable, and reasonable means to determine the hospital's good faith.

Informal Comment: *Mid-Atlantic Collectors Association*

Delegates Collection Activity. Paragraphs 3 and 4 at page 4. Please clarify that hospitals may, should they choose to do so and so long as their outside collection agencies abide by the financial assistance and medical debt regulations, outsource all or any of their responsibilities to a third party under this regulation. In Maryland the phrase "debt collectors" may also apply to third party agencies that perform services beyond traditional debt collection servicing of past due accounts.

Response: Health General 19-214.2(e)(5) contains the good faith requirement. These regulations cannot change statutory law. The language in the regulation is intended to add clarity for industry.

B-1.(7)(d) Reporting to Credit Reporting Agency

Informal Comment: *Mid-Atlantic Collectors Association*

Hospitals as Data Furnishers. The proposed regulations suggest that hospitals may need to consider furnishing data in regard to consumers' payments and resolution of payment arrangements to the consumer reporting agencies. As a general rule, hospitals engage third party vendors to furnish data, should they choose to do so, to the consumer reporting agencies. It does not seem that Maryland hospitals or hospitals elsewhere in the United States are furnishing data, as a general rule, to consumer reporting agencies. See, paragraph [(5)](8) at page 5. MACA recommends striking these provisions unless there is credible documentation that any Maryland hospitals are or have ever credit reported.

Response: Health General 19-214.2 specifically addresses hospitals reporting data to credit reporting agencies. This regulation is based on that law. This regulation does not require reporting to credit reporting agencies. Rather, the regulation addresses situations in which a hospital may choose to report. If a hospital chooses to report and reports adverse information, then the regulation requires them to also report to the agency if the payment plan is satisfied. The remaining provisions are focused on the hospital having a policy regarding credit reporting and following it. The hospital is required to maintain active oversight over any vendors, including debt collectors, that it contracts with to collect debts. Thus, HSCRC expects hospitals to ensure that contracted entities involved in debt collection on behalf of the hospital follow the rules in Health General 19-214.2 and this regulation regarding credit reporting agencies.

B-1.(9) Impact of a Judgment in Maryland & Leins

Informal Comment: *Mid-Atlantic Collectors Association*

By operation of Maryland law (and potentially in other neighboring states) a judgment entered against an individual may automatically be a lien against that individual's property in the county (or Baltimore City) in which the property is located. Subparagraph "b" in [(6)](9) that has been inserted would not harmonize with Maryland law in regard to judgments.

Response: This is a matter of law for the courts to determine and will not be addressed in these regulations. Health General 19-214.2 is clear that " A hospital may not force the sale or foreclosure of a patient's primary residence to collect a debt owed on a hospital bill" and "A hospital may not request a lien against a patient's primary residence in an action to collect debt owed on a hospital bill". These regulations only address what the General Assembly added to Health General 19-214.1 and 19-214.2.

B-1.(11) Garnishments

Informal Comment: ***Mid-Atlantic Collectors Association***

In some instances patients request garnishments or choose to enter into voluntary garnishments. Would patients be free to do so without having the hospital or its debt collector run afoul of provision 11 on page 5?

Response: Health General 19-214.2(g)(4) states "A hospital may not request a writ of garnishment of wages or file an action that would result in an attachment of wages against a patient to collect debt owed on a hospital bill if the patient is eligible for free or reduced-cost care under § 19-214.1 of this subtitle."

B-1.(14)(a) Certified and First Class Mail

Formal Comment: *Health Education and Advocacy Unit*

Proposed Amendment .26B-1(14)

At least 45 days before filing an action against a patient to collect on the debt owed on a hospital bill, a hospital shall send written notice of the intent to file an action to the patient. The notice shall: (a) Be sent to the patient by certified mail [or] and first-class mail;

Reason: Md. Code Ann., Health-Gen. § 19-214.2 (i)(2)(i) says "and" not "or."

Response*:* HSCRC agrees that this change reflects the law.

Informal Comment: *Mid-Atlantic Collectors Association*

"Certified mail." The burden of sending mail "certified" outweighs any potential benefit. It delays the delivery of mail, increases the cost of notifying consumers, and there is no evidence demonstrating consumers do or will "accept" certified or registered mail. The Fair Debt Collection Practices Act and Regulation F already call for first class prepaid notice and an opportunity to dispute all or a portion of a debt prior to commencing further collection action. As we have seen in other states, the onerous requirement of needlessly incurring the cost of certified or registered mail outweighs any possible benefit. There is no demonstrated consumer value or benefit to certified mail and we respectfully request this be deleted from the proposed regulations. On the other hand, there is a significant benefit to providing notice to consumers per consumers' communication preferences that consumers are likely to accept and react to potentially take advantage of financial assistance, repayment options, or even third party sources of repayment that may have expiration dates/timely filing requirements.

Response: This regulatory language is identical to the text of Md. Code Ann., Health-Gen. § 19-214.2 (i)(2)(i). HSCRC does not have the authority to change statutory language.

B-1.(14)(c)(iii) Debt Counseling Services

Formal Comment: *Health Education and Advocacy Unit:*

B-1(14)(c)(iii) [The notice shall include] a statement recommending that the patient seek debt counseling services, including debt counseling services resources the patient may consult that are identified on a list of credit counseling agencies approved pursuant to 11 U.S.C. § 111;

Reason: Pursuant to this federal bankruptcy statute, the United States Trustee maintains a list of approved credit counseling agencies (not debt settlement companies) available to assist consumers. Adding this provision would parallel provisions for notices of intent to foreclose, see Md. Code Ann., Real Prop. § 7- 8 105.1, and would avoid accidentally sending consumers to debt settlement companies.

Response*:* The notices provided to patients under this law and regulation require that hospitals provide patients with the phone number and website address of HEAU. HSCRC would like to keep this complicated

issue as simple as possible for consumers and does not believe that this suggested amendment is helpful or required by statute.

B-1(14)(e)(i) Where to Send an Application

Formal Comment: *Health Education and Advocacy Unit:*

The notice shall be accompanied by--

B-1(14)(e)(i) an application for financial assistance under the hospital's financial assistance policy, along with instructions for completing the application for financial assistance, specific instructions about where to send the application, and the telephone number to call to confirm receipt of the application;

Reason: The HEAU recently started receiving financial assistance applications intended for the hospitals. Consumers advise us that they do not know where to send them and need specific information.

Response*:* HSCRC made this change to the regulation.

B-1(15)(d) Patient Complaints

Informal comment: *Mid-Atlantic Collectors Association*

At present all Maryland citizens are able and encouraged to complain about dissatisfaction with how they are treated by a debt collector by filing a complaint with the CFPB, BBB or appropriate Maryland regulator. What/how would the mechanics be for a new complaint to now also be filed with a hospital?

Need there be a regulation about this and why/how would hospitals be expected to receive, handle, and respond to complaints filed with multiple regulators in addition to themselves?

Response: Multiple state and federal agencies have authority to collect patient complaints and that is not new. Health General § 19-214.2 has required hospitals to provide patients with a mechanism to file a complaint against the hospital, and has required debt collectors to forward complaints to hospitals since 2010. The only substantive change that is being made to this regulation with respect to patient complaints related to debt collectors is the provision related to joint and several liability. This language matches the language that was added to Health General § 19-214.2 in 2021. Whether or not HSCRC includes this in the regulations, hospitals and debt collectors are subject to this statutory language. HSCRC feels that omitting this language from the regulations would be confusing. The regulation does not address what the hospital does with these complaints.

B-1(16) Treatment of Spouses

Informal Comment: *Mid-Atlantic Collectors Association*

Maryland's doctrine of necessaries. Under Maryland's doctrine of necessaries spouses are not liable for one another's debts in the absence of some sort of contractual agreement to guarantee or similar. Wouldn't it make sense to invoke existing law rather than draft a regulation that overlaps it?

Response: The language related to spouses in this regulation is identical to the language in Health General § 19-214.2(h)(1).

B-2(1) Scope / Prepayments

Informal Comment: *Mid-Atlantic Collectors Association*

"Unregulated services." While the jurisdiction of the HSCRC limits its ability to prescribe regulations for, for example, physicians' or other clinicians' bills for services rendered in a regulated hospital – it would and should be expressly permissible if not encouraged for hospitals to take into consideration those accompanying professional charges in evaluating and potentially offering patients repayment alternatives. It is common for physicians and clinicians to request information about and "honor" financial assistance and payment plans previously approved by a hospital. MACA recommends deletion of "except as otherwise required by law or regulation, payment plans that are outside the parameters of these Guidelines are not subject to the Guidelines." This phrasing seems confusing and could impede hospitals and their collection agents from developing repayment plans customized to unique consumers' needs. It is unclear whether this could create more confusion over medical credit cards.

Response: Nothing in this law or regulation prevents hospitals or other providers from providing financial assistance or otherwise supporting consumers in ways that exceed the requirements of Health General §§ 19-214.1and 19-214.2. Other laws, including the Internal Revenue Code, may apply to policies that are outside of the scope of HSCRC's regulatory authority.

Formal Comment: *Health Education and Advocacy Unit*

Prepayments are not expressly excluded from the new payment plan scheme contained in the debt collection statute, Md. Code Ann., Health-Gen. § 19-214.2, and should not be excluded in the regulations. When presented with patient complaints relating to hospitals "demanding" prepayments for services, the HEAU often evaluates the hospital's statutory or contractual authority to demand upfront payment of anything other than copayments in the first instance. Such legal authority, if any, exists outside the Commission's statutes and regulations which are silent about prepayments, including as implied or express prerequisites for nonemergency care. But any claim for prepayment must be predicated on a bill, and presentment of a bill triggers a hospital's obligation to provide the information sheet describing the hospital's financial assistance policy and the patient's rights with regard to hospital billing and collection, including access to income-based payment plans with monthly payments capped at 5% of income. Md. Code Ann.,

Health-Gen. § 19-214.1(f)(1)(i)-(ii) and 19-214.2(e)(2)(ii). Hospitals seeking prepayments without providing the required information risk running afoul of Md. Code Ann., Com. Law § 14-202(8)(“ In collecting or attempting to collect an alleged debt a collector may not [c]laim, attempt, or threaten to enforce a right with knowledge that the right does not exist”).

We ask that .26B-2(1) Scope, be amended to simply provide:

“(a) As described in this regulation, the Guidelines apply to any payment plan offered by a hospital to a patient to pay for hospital services.”

Because that amendment would render .26B-2(3) Notice Requirements moot, we also ask the Commission to strike that provision.

Should the Commission elect to exclude prepayments from the payment plan provisions, at a minimum, when asking patients to make otherwise legally and contractually authorized prepayments, hospitals must:

1. make a determination regarding presumptive eligibility;

2. advise the patient about financial assistance and process any request for financial assistance; and

3. advise the patient about the availability of payment plans, including information that they are entitled to have their payment amounts capped.

Response*:* HSCRC has added language to the “Scope” section of the regulations to require additional notice to consumers who are pre-paying amounts before receiving a hospital service to ensure that those patients are aware of the availability of financial assistance and payment plans under this regulation.

Informal Comment: *Health Education and Advocacy Unit*

As drafted, the proposed regulations at B-2(1)(a) state that the statutorily

required payment plans do not apply if the hospital seeks payment, in advance, for services.

The HEAU objects to this interpretation. Prepayments are not expressly excluded from the new payment plan scheme contained in the debt collection statute, Md. Code Ann., Health-Gen. § 19-214.2, and should not be excluded in the regulations.

When presented with patient complaints relating to hospitals “demanding” prepayments for services, the HEAU often evaluates the hospital’s statutory or contractual authority to demand upfront payment of anything other than copayments in the first instance. Such legal authority, if any, exists outside the Commission’s statutes and regulations which are silent about prepayments, including as implied or express prerequisites for non-emergency care. But any claim for prepayment must be predicated on a bill, and presentment of a bill triggers a hospital’s obligation to provide the information sheet describing the hospital's

financial assistance policy and the patient's rights with regard to hospital billing and collection, including access to income-based payment plans with monthly payments capped at 5% of income. Md. Code Ann., Health-Gen. § 19-214.1(f)(1)(i)-(ii) and 19-214.2(e)(2)(ii). Hospitals seeking prepayments without providing the required information risk running afoul of Md. Code Ann., Com. Law § 14-202(8)("In collecting or attempting to collect an alleged debt a collector may not [c]laim, attempt, or threaten to enforce a right with knowledge that the right does not exist") and the Consumer Protection Act.

We ask that .26B-2(1) "Scope" be amended to simply provide: "(a) As described in this regulation, the Guidelines apply to any payment plan offered by a hospital to a patient to pay for hospital services."

Response: HSCRC continues to believe that prepayments of estimated amounts due differ from the payments and payment plans for the actual amounts due that are billed to patients after a hospital service is provided.

B-2(2)(a): Are All Payment Plans Income-Based?

Informal Comment: *Maryland Hospital Association*

Health General 19-214.2 (E)(3)(I) reads that "THE COMMISSION SHALL DEVELOP GUIDELINES, WITH INPUT FROM STAKEHOLDERS, FOR AN INCOME–BASED PAYMENT PLAN OFFERED UNDER THIS SUBSECTION..."

Notwithstanding HSCRC's published payment plan guidelines, could this language be interpreted to read HSCRC needs to develop guidelines for income based repayment plans but not all payment plans are required to be income based? Particularly the emphasis on "AN" income-based payment plan.

Response*:* HSCRC was asked to review the statute to determine if income-based payment plans were required. Based on the lack of clarity in the law, HSCRC has determined that a hospital must offer an income based payment plan to patients, and document that the patient declined such a plan before entering into a non-income-based payment plan.

B-2(2)(b) & (3)(a) Non-Residents

Formal Comment: *Health Education and Advocacy Unit:*

.26B-2(2)(b) Treatment of Nonresidents.

(i) The Guidelines do not prevent a hospital from extending payment plans to patients who are not described in §B-2(2)(a) of this regulation. Except as otherwise required by law or regulation, payment plans for patients who are not described in §B-2(2)(a) of this regulation are not subject to the Guidelines.

(ii) Hospitals shall inform nonresidents who are not eligible for a payment plan that they are ineligible. The written notice shall be provided as a stand-alone document accompanying any document that references the availability of a payment plan.

.26B-2(3) Notice Requirements.

(a) Notice of Availability of a Payment Plan.

(i) Posted Notice. A notice shall be posted in conspicuous places throughout the hospital, including the billing office, informing [patients] Maryland residents of the availability of a payment plan and whom to contact at the hospital for additional information.

Reason: Maryland hospitals frequently provide services to nonresident patients who are not entitled to participate in the payment plan scheme. If hospitals give all patients the same information sheet with information about financial assistance and payment plans tailored to Maryland residents, nonresident patients may be misled into believing they might qualify and lose the opportunity to obtain services elsewhere if they wish.

Response*:* HSCRC has accepted the change to B-2(3)(a)(i).

HSCRC does not feel that it is appropriate to tell patients that they may not qualify for a payment plan, when the policy is that hospitals may, but are not required to provide a payment plan to those patients. If the hospital provides a payment plan to nonresidents but is required to tell nonresidents that they do not qualify for payment plans, that is a nonsensical outcome and one that will discourage nonresidents from taking advantage of payment plans, if that financial tool is available to them. HSCRC added language to B-2(3)(a)(ii) to address this concern.

Informal Comment: *Health Education and Advocacy Unit*

The HEAU requests that .26B-2(2)(b) be amended to read, “These guidelines do not prevent hospitals from extending payment plans to patients not covered by these guidelines, or for services not otherwise required by these guidelines.”

Response: HSCRC amended this section to address services as well as patients.

B-2(3)(a) Notice of Availability of Payment Plans

Informal Comment: *Health Education and Advocacy Unit*

The HEAU suggests additional language be added to the notice requirements outlined in .26B-2(3)(a) to address consumers who make payments online. The HEAU suggests this language:

(v) Online Payment Portal. On both the page of the online payment portal that states the amount due, and where the consumer enters the amount being paid by the consumer, the hospital shall provide, in

the same font and style as the amount due notification, notice informing Maryland residents of the availability of an income-based monthly payment plan and information, including a telephone number and email address, in order to contact the hospital for additional information.

Response*:* HSCRC made this change.

Informal Comment: *Mid-Atlantic Collectors Association*

"Notice" of income-based payment plans. Requesting clarification for paragraph 3 on page 8 that as in the case of notices about patients' bills of rights or rights under the Health Insurance Portability and Accountability Act of 1996 and accompanying regulations ("HIPAA"), "notice" (and downloadable or fillable financial assistance application) can be deemed given if posted prominently in any physical location or online location to which or of which patients access. It may make sense to also consider whether or not hospitals' debt collectors should also be asked to publish this "notice" on their websites or online patient portals along with a downloadable/fillable financial assistance application.

Response: Language was added to the regulations in two places to require this notice on debt collector websites or billing portals. Placement on the website or online payment portal should be based on the best interest of the patient.

B-2.(3)(b): Notice of Payment Plan Terms

Formal Comment: *Johns Hopkins Health System*

We appreciate the HSCRC's intent in setting forth this guideline to ensure patients have ample notice before their first payment is due. If the HSCRC requires notice of payment plan terms, we urge the HSCRC to allow both written and electronic delivery, particularly if the patient has self-selected a payment plan through electronic means.

Response*:* HSCRC intended to allow for both written and electronic delivery. HSCRC has edited 26.A.(7) to make this clearer.

B-2.(3)(c): Joint Hospital/Physician Services Billing Practices

Formal Comment: *Johns Hopkins Health System*

In order to provide a complete picture of services received, JHHS currently bills patients for all services together – inclusive of physician fees, home health services, pharmacy charges and hospital charges. This allows patients to develop payment plans for both hospital and physician charges. If the payment plan

guidelines become unreasonable, there will be one payment plan process for hospital charges and another process for physician charges. By driving a process for only hospital-based services and regulated clinics, hospitals risk driving disconnected and conflicting expectations for patients as they seek to understand the services received and amounts owed. The law is limited to only hospital fees, so JHHS urges the HSCRC to make every effort to establish guidelines that support the aligned processes that are in place today.

Formal Comment: *Health Education and Advocacy Unit*

We also ask the Commission to strike a related provision, proposed .26B2(4)(c) Unregulated Services ("The Guidelines apply only to hospital services that are regulated by the HSCRC. The Guidelines do not apply to services that are not regulated by the HSCRC, including physician services."). This restriction is not expressed in the debt collection statute, conflicts with the remedial nature of the statute, and is inconsistent with the tenet of 26 CFR § 1.501(r)–4(b)(1)(i).

Response*:* HSCRC's legal authority only applies to hospital services (Health General 19-211). HSCRC does not have authority over physician services.

B-2(7) Calculation of Income

Informal Comment: Health Education and Advocacy Unit

It is unclear what income is counted under .26B-2(7)(a).

Response: HSCRC added language about tax information. HSCRC is not adding specific details on permitted excluded income types in this regulation.

Informal Comment: Mid-Atlantic Collectors Association

Question about calculation of monthly payment amounts and whether or not this might trigger Fair Credit Reporting Act "adverse action" responsibilities (see #7 at page 9).

Response: Maryland law requires that hospitals limit the payments due under income-based payment plans to 5% of monthly income, which requires a calculation of income. If this conflicts with FCRA, HSCRC will not be able to fix that conflict through regulation, unless there is something specific about HSCRC's approach to calculating income that creates the conflict. HSCRC is not aware that the regulations, independent of the statute, create a conflict, and thus HSCRC is not making changes to the regulation based on this comment.

B-2.(7)(c-d): Family and Individual Income Inconsistency & Calculation of Income

Formal Comment: *Health Education and Advocacy Unit*

After careful consideration of the debt collection statute and practical realities (income can be hard to document and prove; non-traditional households; many patients are not wage earners), the Workgroup agreed that household income should be divided by the number of household members in order to calculate a patient's adjusted gross income for the purpose of determining the capped monthly payments to be made under the plans. The HEAU is concerned that use of the term "patient's adjusted gross income" in .26B-2(4)(d)(i) is inconsistent with the entirety of .26B-2(4)(d) (iii) Determining the Patient's Pro-Rata Share of Income, and was not intended by the Workgroup. We have discussed our concerns with staff, referred them to informal comments we submitted on these issues during the Workgroup, and expressed our willingness to discuss the issues further.

Formal Comment: *Maryland Hospital Association*

"A statutory change to use the term 'family income' in Health – General § 19-214.2 would allow for greater consistency between the financial assistance and payment plan policies and reduce administrative burden for patients and hospitals." MHA strongly encourages HSCRC to consider legislative action to align this inconsistency, as well as any other areas of the authorizing statute that impede the success of Maryland's Total Cost of Care Model.

Formal Comment: *University of Maryland Medical System*

We strongly encourage HSCRC to consider legislative action to align the income eligibility criteria for financial assistance and payment plans to be based on household or family income. The requirement for hospitals to calculate an individual patient's pro-rata share of adjusted gross income creates an additional burden on hospitals and patients. Use of consistent eligibility criteria will make it easier for patients to understand.

Informal Comment: Johns Hopkins Health System

JHHS believes there should be consistency in calculation of income. The regulations clarify that household expenses should be considered when determining an income-based payment plan; however, as it currently reads, the income is calculated based on individual income, not household income.

Recommendation: JHHS recommends that household income, as opposed to individual income be considered when determining income-based payment plans.

Response: The law uses the term "individual income." As commenters noted, a change to "family income" would require a statutory change. HSCRC has used the concept of pro-rata income to avoid some of the unintended consequences that result from using individual income. For example:

- **A family with a single high-income earner.** If another member of the family who has no individual income (such as a stay-at-home spouse or a child) has out-of-pocket expenses from a hospital bill, the patient would not qualify for financial assistance (due to the use of "family income") but the patient would appear not to owe any monthly payments under a payment plan (since the cap on monthly payments is based on individual income, which in this case, is $0). This would allow higher income families to avoid paying hospital bills for family members with no individual income, increasing bad debt for hospitals. This seems like an unintended outcome of the current statutory language.
- **A family with an income close to, but above the amounts to qualify for financial assistance, a single wage earner, and multiple family members.** In this case, if the patient with the out-of-pocket expenses was the wage earner, the application of "individual income" to determine payment plan amounts would result in a higher monthly payment than if the size of the family was considered. For example, consider a family of four had a single earner that earned $81,800 a year in 2022 ($50 above the 300% FPL amount for a family of 4, and thus not eligible for reduced cost care under HG §19-214.1), and that income earner was the patient with out-of-pocket costs. The maximum monthly payment plan amount using the patient's individual income and the 5% income limit in law would be $341 (or 20% of the monthly income of the family, assuming the individual income was divided among all the family members equally). If family size was considered, the monthly payment maximum would be $85.

While using individual income without adjustment would be a simpler approach, HSCRC took this approach to mitigate the problems raised above.

B-2.(4)(c)-(e): Requirement of Income Information, Attestation, & Documentation of Income

Formal Comment: *University of Maryland Medical System*

UMMS currently allows patients to self-select payment plan terms that they can afford without requiring them to submit documentation or disclose information on their income, expenses, or household size. This can be completed in a quick phone call. The Guidelines will require patients to apply for financial assistance, which can take up to fourteen days to determine eligibility, and provide documentation or attest to their income, expenses, and household size, which may be seen as an unnecessary invasion into their privacy and will significantly lengthen the application process. It also places limitations on our ability to

implement self-service payment plan options which would allow patients to create payment plans independently online. This will be perceived by patients as a step backwards in terms of our ability to provide convenient options for patients to manage their financial experience. We strongly urge that patients are allowed to continue to self-select payment plan terms that they can afford, without the undue burden to provide documentation or attestation. Should a patient require assistance in calculating their income in order to determine the appropriate monthly payment that does not exceed 5% of their income, we would gladly provide that assistance. However, it should not be imposed upon all patients that request a payment plan.

Formal Comment: *Johns Hopkins Health System*

In order for the patient attestation to be most effective, JHHS recommends the attestation appear before and after a payment plan is proposed by the hospital. The proposed payment plan could be formulated using known historical payment patterns of the patient when available. The attestation of income would then become available to create an alternative payment plan, if desired. This process allows both patients and hospitals the flexibility required to come to reasonable agreements regarding payment plans.

However, if the duration and approach to payment plans do not provide this needed flexibility,

the hospitals will have no choice but to implement income verification processes impacting the

large patient population that successfully uses the current payment plan process without such

verifications.

Response: HSCRC staff interpret the law as requiring hospitals to determine an individual's income for the purpose of income-based payment plans. These regulations reflect this requirement. These regulations allow hospitals to use patient self-attestation to determine income. HSCRC staff believe that a patient's self-attestation of income should not be subject to income verification and thus should be less burdensome than these comments suggest.

HSCRC has changed the draft regulation to allow for non-income-based payment plans. HSCRC requires that hospitals collect written consent from patients entering these plans that clearly states that they were offered an income-based plan and declined that offer.

B-2(9) Expenses

Informal Comment: *Maryland Hospital Association*

Remove the Requirement to Consider Household Expenses When Establishing Income- Based Payment Plans

The proposed regulations require a hospital to consider a household's expenses when determining an income-based payment plan. We ask HSCRC to strike this section because:

- This approach is not required in statute as the statute and the proposed regulations are income based
- Income-based payment plans are based on individual not family income, as we have suggested for consistency. If family income is not considered, household expenses should not be considered
- Asking for this level of information may discourage patients from engaging in reaching a solution

Response: Ability to pay is a cornerstone of credit. In the development of the payment plan guidelines, stakeholders noted that household expenses may affect a patient's ability to pay back medical debt under a payment plan. The only expense implicitly addressed in the law was medical debt that meets the definition of financial hardship (this topic is addressed in guideline (5)(a)). HSCRC staff included this language to encourage hospitals to consider patient circumstances.

B-2.(11): Duration of Payment Plans

Formal Comment: *Johns Hopkins Health System*

The proposed regulations indicate that installment payments are capped at 5% of the patient's household gross adjusted income. Given that some patients may wish to pay their bill earlier, we urge the HSCRC to ensure ample flexibility for hospitals to offer patients the option to pay installments of more than 5% of their household gross adjusted income if desired. This approach provides patients the ability to structure their plan and payment timelines as needed, and also allows hospitals to close accounts according to the patient's ability to pay. It is not the hospital field's intention to steer patients to higher installment amounts; rather, hospitals aim to give patients choices regarding how to best structure their own finances.

Additionally, in order to maintain the integrity of the healthcare system, it is crucial that the payment plan guidelines allow for timely recoupment of funds. Hospitals are unable to provide unlimited loans for services rendered. In our experience, patients of all income levels enter payment plans for a myriad of reasons; our current processes ensure that patients only pay what they can afford and there are many options for assistance if they cannot afford their bill.

Response: Health General 19-214.2 is clear that monthly payment amounts under income-based payment plans may not exceed 5 percent of income. HSCRC does not believe that income-based payment plans that contain a higher monthly amount are legal. Patients may choose to prepay any portion of the debt, as noted in B-2(15).

The draft regulation has been amended to allow for non-income based payment plans, which would allow for higher payment amounts than the income-based payment plans.

B-2. (13) Partial Payment

Formal Comment: *Health Education and Advocacy Unit:* .26B-2(7)(d) Partial Payment Application. Upon receipt of a partial payment from a patient, a hospital must confirm in a written communication that the partial payment reduces the principal balance and may not apply the partial payment to future monthly payments without first receiving express written consent from the patient. After applying a partial payment, a hospital must confirm the new balance in a written communication.

Reason: Hospitals risk exposure for debt collection violations if they misapply a lump sum payment. If the hospital does not apply a lump sum to principal, it could cost the consumer more interest and extend the life of the loan. Misapplication of payments has been the subject of federal enforcement actions against student loan servicers.

Response: The commenter cites a situation from the student loan industry in which servicers applied partial payments in ways that artificially increased the borrower's costs. This suggestion seeks to eliminate the possibility of similar abuses in medical debt collection. However, Medical debt collection and student loan debt collection are subject to different legal and regulatory schemes. Specifically, Maryland law limits the interest that can be applied to hospital debt. This limits the economic incentives for a hospital to manipulate the application of payments to force the patient to pay more.

In addition, HSCRC is concerned that this suggested change may result in harm to the consumer. For example, suppose the consumer has a payment plan requiring monthly payments of $200. The consumer knows they must pay $200 on July 1st. The consumer sends a partial payment of $70.00 on June 18, thinking the hospital will apply that to the July payment and the consumer now only needs $130 for the July payment. Under this proposed change, the consumer would still need to pay $200 in July because the hospital would be mandated to apply the $70.00 to reduce the principal balance.

This change would also add administrative burdens to hospitals and consumers. On the receipt of a partial payment, the hospital would be required to send written communication to the patient stating that the partial payment reduces the principal balance. The suggested change to the regulation is unclear whether this communication must also advise the patient that the hospital may not apply the partial payment to future payments without the patient's express written consent. Any patient would then need to send written notice

to the hospital that the partial payment should be applied to a future payment. The hospital would then need to set up a process for soliciting, receiving and acting on such consent. Additionally, after the hospital applies the partial payment, the hospital would need to send a written communication to the patient confirming the new balance, potentially in addition to normal monthly statement balances. The suggested change to the regulation is unclear as to whether the hospital can accomplish both requirements in a single communication or if it must communicate with separate written notices.

HSCRC has added language to ensure that hospitals apply partial payments in the manner that is most favorable to the patient.

B-2.(14): Interest

Formal Comment: *Johns Hopkins Health System*

JHHS currently does not charge interest. However, hospitals may be forced to begin charging interest to both maintain the integrity of the payment plan and encourage patients to pay in a timely fashion. The current payment plan process effectively balances the needs of both patients and hospitals. If policies are enacted that change this balance, other mechanisms including charging interest may need to be implemented.

Response: Health General 19-214.2 permits hospitals to charge interest in payment plans and this is reflected in the regulations.

B-2(14)(d). Interest Rate

Informal Comment: *Maryland Hospital Association*

Variable interest rate preferred

Response: The Maryland Constitution states that “The Legal Rate of Interest shall be Six per cent per annum, unless otherwise provided by the General Assembly.” Given the lack of specification in Health General § 19-214.2, HSCRC is using the Constitutional rate.

B-2.(15)(b) Early Payment

Formal Comment: *Health Education and Advocacy Unit*

(b) No Fees or Penalties. A hospital may not assess fees or otherwise penalize early payment of a payment plan [provided by a patient].

Reason: The statute is silent about the source of early payments which seems irrelevant, and as drafted could suggest payments made by others lack the no prepayment penalty protection.

Response: HSCRC agrees with this change.

B-2.(17): Modifications to Payment Plans

Formal Comment: *University of Maryland Medical System*

The Payment Plan Guidelines state that a hospital may only request recalculation of a patient's income for payment plans that exceed three years in length, no more than once every three years, and that if a patient declines to provide income information and their payment plan is in good standing, the hospital may not make changes to their payment plan agreement. We strongly encourage HSCRC to limit reconsiderations to payment plans that exceed one year in length and allow recalculation annually. We also urge that the HSCRC strike the language that prevents the hospital from making any changes to payment plans if a patient fails to provide income information for the purpose of recalculation.

Response: This regulation allows hospitals to change the monthly amount due under an income-based payment plan every three years based on changes in patient income. The three-year period represents a compromise between viewpoints from stakeholders who participated in the workgroup. HSCRC staff believe it is important for hospitals to have the option to change payment amounts in income-based payment plans based on changes in patient income, given that HSCRC staff expect that payment plans will be longer under this new regulatory regime than they have been in the past. In response to stakeholder comments, HSCRC staff drafted this provision to give hospitals the flexibility to change the payment amount under an income-based payment plan based on the patient's income, but hospitals are not required to recalculate payment amounts under this subsection. Based on feedback from the workgroup, HSCRC added patient protections to this provision, including that income-based payment plans continue under the prior terms if a patient does not respond to the hospital's request for income information.

B-2(18) Treatment of Missed Payments

Informal Comment: *Medstar*

Want to confirm that a missed payment can occur once in every 12-month period, and thus could happen multiple times over the course of a payment plan that lasts longer than 12 months?

Response: Yes.

Informal Comment: *Medstar*

How does this interact with B-2(10) related to multiple payment plans. Medstar uses a "joint statement." What happens if additional amounts are added to the payment plan? Does the clock start over on the missed payment?

Response: Newly added amounts arguably constitute a new payment plan, resulting in a restart of the clock. HSCRC has not amended the regulation to address this topic.

Formal Comment: *Health Education and Advocacy Unit*

.26B-2(10) Treatment of Missed Payments.

(ii) The hospital shall permit the patient to repay the missed payment amount at any time, as determined by the patient, including through a set of partial payments. Unless otherwise directed by a patient, the hospital shall apply all other payments made by a patient to the amount due in the month in which the patient's payment is received.

Reason: Federal courts in Maryland have evaluated whether loans made under certain Title 12 provisions (installment loans under CLEC), require payments to be applied in a certain order. The courts looked at the language of retail installment sales contracts. Absent language in the written payment plan akin to such contracts, we believe the regulations should explain the order of payments to clarify how the payment will be applied in circumstances where a consumer can make 11 out of 12 payments and be considered current. We also disfavor any ambiguity that could allow interest to accumulate at a higher rate for consumers.

Response: HSCRC understands that the law and these proposed regulations may result in two two separate payment schedules for the same obligation:

(i) the normal scheduled monthly payments; and

(ii) the payments needed to fully repay the missed payment.

These two payment cycles could lead to confusion. However, the suggested change may add to, rather than clarify, this confusion. For example, "all other payments" is not defined and HSCRC is not sure what is intended by this language. It also does not clarify how the hospital differentiates between make-up payments and all other payments.

In addition, the suggested change has consequences that could be detrimental to the consumer. Suppose the consumer missed the March payment and has established a schedule to make it up over 1 year. The consumer continues to struggle and does not make its June payment until July 2. Under this provision, the hospital must apply that payment to the July payment, meaning the consumer missed the June payment and the hospital may now declare the patient in default. This result is contrary to the remedial intention of the legislation.

HSCRC has added language to ensure that hospitals apply partial payments in the manner that is most favorable to the patient.

B-2(19) Treatment of Loans and Extensions of Credit

Informal Comment: *Mid-Atlantic Collectors Association*

A number of hospitals have affiliated but separate physician groups that render treatment in ERs and other places, which would have separate bills for those dates of service. Acknowledging that HSCRC doesn't regulate these groups, how would that fit with number 19? Would there be a chance for clarification?

Response: HSCRC added language about medically necessary hospital services to clarify the scope of this provision.

B-2(22). Default

Formal Comment: *Health Education and Advocacy Unit*

.26B-2(14). Default. If a patient defaults on a payment plan and the parties are not able to agree to a modification, then the hospital shall follow the provisions of its collection and write-off policy for the collection of debt established in accordance with this regulation, before a hospital may write this debt off as bad debt. In the event of a default where the parties are not able to agree to a modification and the hospital refers the debt to collection, the default constitutes an acceleration of the underlying debt.

Reason: Maryland case law holds that each installment tolls the statute of limitations unless "some affirmative act" by a debt collector accelerates the debt. Until then, each default on a separate installment gives rise to a separate statute of limitations. Since these payment plans could exist for many years, which was a concern of the Workgroup, the regulations should identify what kind of default accelerates the loan balance. This avoids an argument by debt collectors that the statute of limitations doesn't begin until the last installment would be due. Consumers should not receive surprise lawsuits more than three years after their default.

Response: The Commentor requests this additional language because the Maryland statute of limitations does not begin to run on installment loan obligations until the creditor accelerates the underlying indebtedness. If the creditor does not accelerate the indebtedness, the statute of limitations runs from the patient's most recent payment, meaning the statute of limitations resets each time the patient makes a payment. HSCRC understands that there is a broad and complex debate about this topic related to commercial debt and does not feel it is appropriate to take a position in this debate in these regulations. It is not clear whether the impact of this change will be positive or negative for consumers. In addition, this change seems contrary to the intent of the legislation, which is clearly to allow for extended repayment periods. The proposed change could result in more medical debt going to civil litigation. Finally, HSCRC

notes that it is likely that debt collectors will already be engaged in servicing hospital debt at the time of the default.

Informal Comment: Issue of scheduling elective procedures for patients in arrears.

Response: Patients who are not in default on a payment plan are not in arrears. The fact that a patient is in a payment plan should not be taken into account by a hospital when scheduling services. HSCRC has added language to the regulation to clarify this.

B-2(23) Non-Income Based Payment Plans

Informal Comment: Maryland Hospital Association

We support the Health Services Cost Review Commission's overall approach to allow non-income based payment plans. This allows appropriate flexibility for each hospital to meet the needs of each individual patient.

Response: Thank you.

Informal Comment: Medstar

If eligible for an income-based payment plan and a patient misses a payment on a non-income-based payment plan, does the notice in each of the bills count for notification or will a separate notification about the option to enter an income-based plan need to go out?

Response: HSCRC added language to clarify that the notice provided with bills before the person is in default is not sufficient.

Informal Comment: Health Education and Advocacy Unit

The HEAU supports offering non-income-based payment plans to consumers not otherwise eligible for income-based payment plans, but objects to such plans being offered in lieu of the statutorily required plans. Should the Commission retain these payment plan types, the HEAU requests that the Commission include public-facing hospital reporting requirements to enable the Commission and the public to evaluate the nature of the plan types ultimately entered into by consumers, specifically to identify improper steering.

Response: HSCRC will consider adjusting the DCFA reporting form in future years to collect information on both income-based and non-income-based payment plans.

Informal Comment: Johns Hopkins Health System

As drafted, the proposed regulations require hospitals to collect written consent from, and provide written notification to, patients prior to entering a non-income-based payment plan. JHHS has a number of patients that establish payment plans over the phone, for these patients it would be better to allow alternative

communications and consent. Patients would appreciate the opportunity to establish payment plans on that one phone call, rather than calling back after written communication happens. This is considered best practice for non-face to face communication with patients. This process would allow more patients to access payment plans, making the process less burdensome.

Recommendation: JHHS recommends that the regulations include a provision for payment plans to be set up via discussion (i.e., phone call) with the patient. Permitting the patient to give oral consent will allow the associate to adequately document the patient's consent, instead of requiring a patient's signature.

Response: HSCRC edited the regulation to remove the specification that consent must be written.

B-2(24) Steering

Informal Comment: Mid-Atlantic Collectors Association

Other third party sources of payment for hospital bills. Requesting clarification on how or whether the HSCRC can encourage private, commercial, governmental and other third party payers to provide transparent, accessible resources to consumers making it possible for patients to understand, access and apply for any third party payment with relative ease.

Response: HSCRC does not have authority over third-party payer communications with consumers.

Informal Comment: Mid-Atlantic Collectors Association

In .26.A.(10) the definition of "non-income-based payment plan" is silent as to whether or not it would include medical credit cards potentially offered by third parties to patients in conjunction with hospital debt that is the subject matter of this regulation. MACA requests clarification as to whether or not the definition is meant to include or exclude medical credit cards. The potential importance of clarity on medical credit cards that may be offered to patients by third parties would also seem pertinent in "B-2" guidelines for hospital payment plans. Does this apply to medical credit cards offered directly or indirectly by hospitals?

Response: New language has been added to this regulation related to patient steering to ensure that medical credit cards are not used to avoid this regulation's guidelines on payment plans.

B-3(1)(a) Financial Assistance Policy- Written Notice

Formal Comment: *Health Education and Advocacy Unit:* .26B-3(1) Financial Assistance Policy

(a) On or before June 1, 2009, each hospital and on or before October 1, 2010, each chronic care hospital under the jurisdiction of the Commission shall develop a written financial assistance policy for providing free and reduced cost medically necessary care to low-income patients who lack health care coverage or to patients whose health insurance does not pay the full cost of the hospital bill. A hospital shall

provide written notice of the hospital's financial assistance policy to the patient, the patient's family, or the patient's authorized representative before discharging the patient and in each communication to the patient regarding collection of the hospital bill. A patient may opt out of electronic communications by informing the hospital or debt collector orally or through written communication.

Reason: Sick and recovering patients need to have written financial assistance policies so that they may process at their own pace information about how to apply for financial assistance and payment plans.

Response: HSCRC agrees with this change.

B-3(1)(a)(iv): Geographic Limitations

Informal Comment: Some hospitals have limited their financial assistance to their service areas (the zip codes that most of their patients reside in). This is likely due to an interpretation of language in existing law related to reduced-cost care that says the discount should be provided "in accordance with the mission and service area of the hospital." This language was added to the statute in 2009. This language does not appear in the statutory provisions related to free care. Some commentators would like clarification that there is no geographic limitation for residents of Maryland allowed for financial assistance.

Response: Given the current language of the law, HSCRC does not feel it has authority to prevent hospitals from limiting reduced-cost care to their service area in their financial assistance policy. The provisions of Health General § 19-214.1 related to free care do not refer to "service area." HSCRC has added clarifying language to these regulations that prevents hospitals from limiting free care to their service area, ensuring protections for the lowest income families in Maryland.

Informal Comment: At least one Commentator is concerned that Maryland hospitals near state borders are soliciting patients from out-of-state and then denying them financial assistance.

Response: HSCRC believes that the financial assistance that is required under Health General § 19-214.1 applies to Maryland residents, regardless of insurance status, citizenship status, or immigration status. State law does not supersede federal law. Under federal tax law, nonprofit hospitals are required to provide financial assistance to patients. Hospitals must comply with federal law with respect to all patients, regardless of the patient's state of residency.

B-3(1)(a)(v): Emergency, Urgent, and Elective Treatment

Informal Comment: Some hospitals have limited their financial assistance to emergent care and/or excluded elective procedures. Given that many elective procedures must be done in the hospital and

financial assistance is limited to medically necessary services, some commentators would like to make sure hospitals are prohibited from having these limitations in financial assistance policies.

Response: In January, 2023, HSCRC sent a memo to hospitals to clarify that financial assistance policies should not be limited to urgent and emergent care. HSCRC is further clarifying this issue by adding language to these regulations.

B-3(1)(b) Limitation on reducing Income Thresholds

Informal Comment: *Adventist*

Strike "A hospital whose financial assistance policy as of May 8, 2009, provides for free or reduced-cost medically necessary care to a patient at an income threshold higher than those set forth above may not reduce that income threshold." Hospitals who had higher thresholds at that time have been locked into those higher thresholds since 2009.

Response: HSCRC has decided to remove this language from the regulation. HSCRC believes that all hospitals should be subject to the same rules. HSCRC encourages hospitals to continue to be generous in their financial assistance policies.

B-3(7) and (8) Uniform Financial Assistance Application

Informal Comment: *Maryland Hospital Association*

We agree allowing hospitals to use a financial assistance application that meets the requirements of the "Uniform Financial Assistance Application" is appropriate. All hospitals meet the requirements of the Uniform Financial Assistance application, and we appreciate HSCRC's efforts to modernize this approach.

Response: Thank you.

Informal Comment: *Mid-Atlantic Collectors Association*

What is the status of the Uniform Financial Assistance form?

Response: There is a version of this form on the HSCRC website. Debt collectors should work with each hospital, which all have a version of this form. HSCRC is actively working on updating this form and will release it after these regulations are final.

C.(5)(a) Reference to No Surprises Act

Formal Comment: ***Health Education and Advocacy Unit***

Proposed amendment to .26C-5(a): <u>In addition to the good faith estimate requirements in PHS Act Sec. 2799B-6, the No Surprises Act,</u> (text unchanged). Reason: See above

Reason: This long-standing provision about estimates requires updating with a reference to the No Surprises Act, which is in effect. PHS Act Sec. 2799B-6 of the No Surprises Act requires hospitals to provide pretreatment estimates when an individual schedules an item or service at least three business days in advance. Providers and facilities must, within one business day of the date of scheduling, ask about the individual's insurance coverage status and whether the individual is seeking to have a claim submitted to the individual's plan or coverage, and provide a good-faith estimate of the expected charges to the plan or issuer or to the individual if they are not insured or are not seeking to have a claim submitted to their plan or coverage. If the individual schedules the item or service at least 10 business days in advance, the provider or facility must meet these requirements within three business days of the date of scheduling. Though the provisions are temporarily delayed for patients using insurance, we do not want the proposed regulation to suggest that the NSA provisions do not apply.

Response: HSCRC accepted this change.

maryland
health services
cost review commission

Update on Medicare FFS Data & Analysis

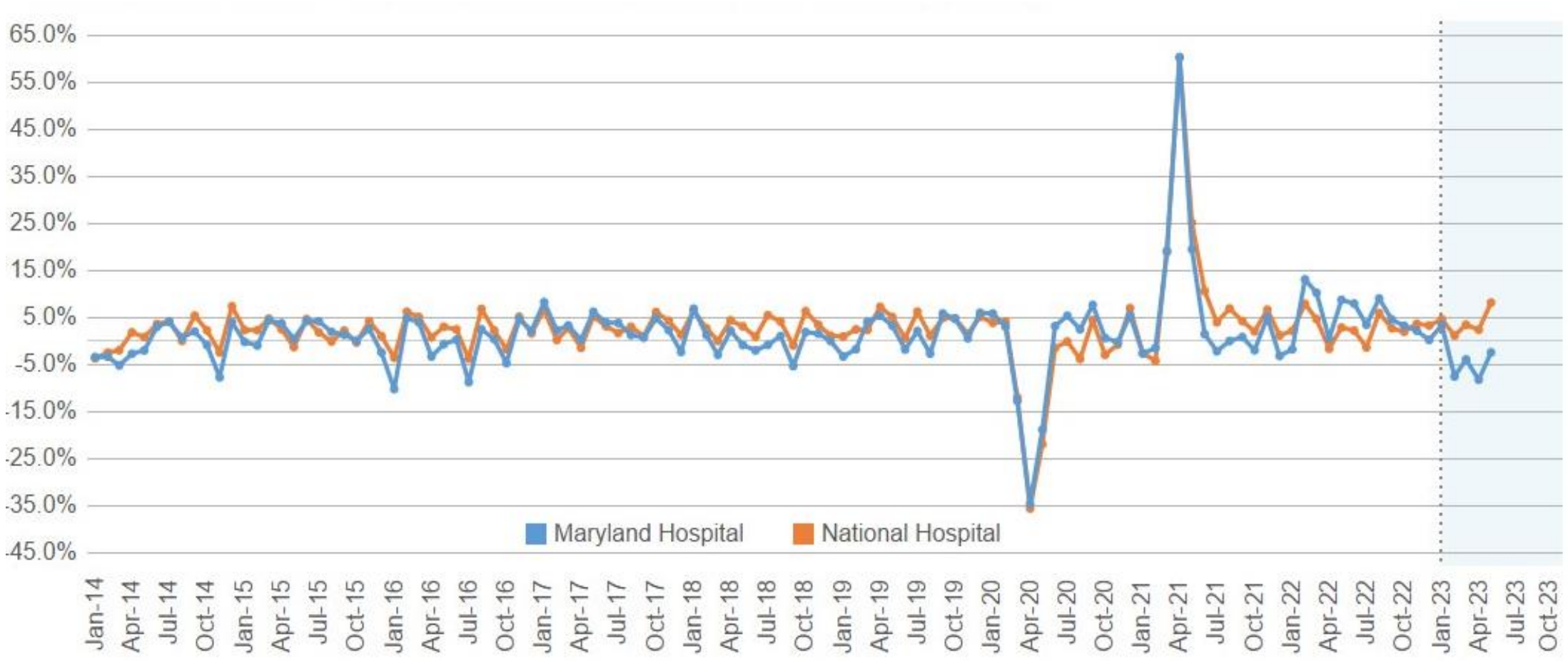
September 2023 Update

Data through May 2023, Claims paid through July 2023

Data contained in this presentation represent analyses prepared by HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare FFS patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation and EMR conversion could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

Medicare Hospital Spending per Capita

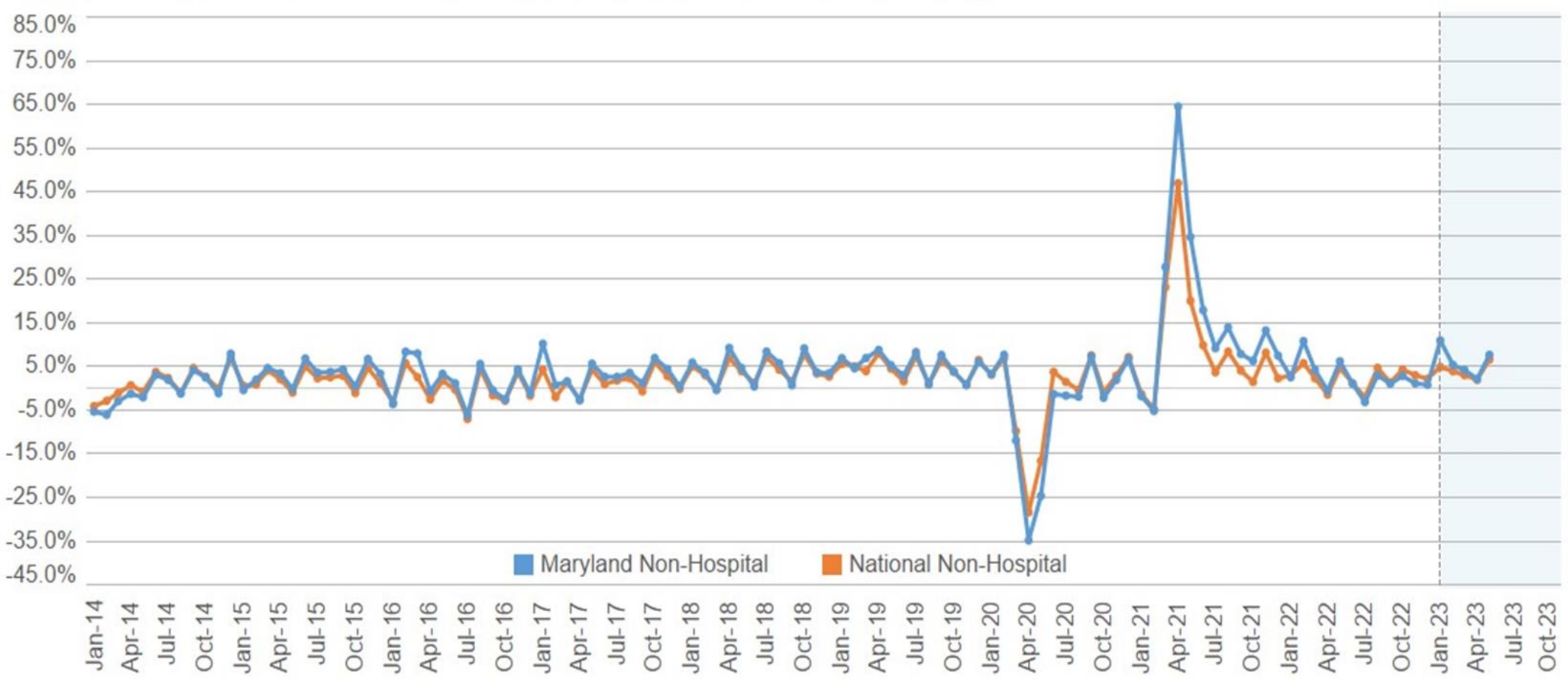
Actual Growth Trend (CY month vs. Prior CY month)



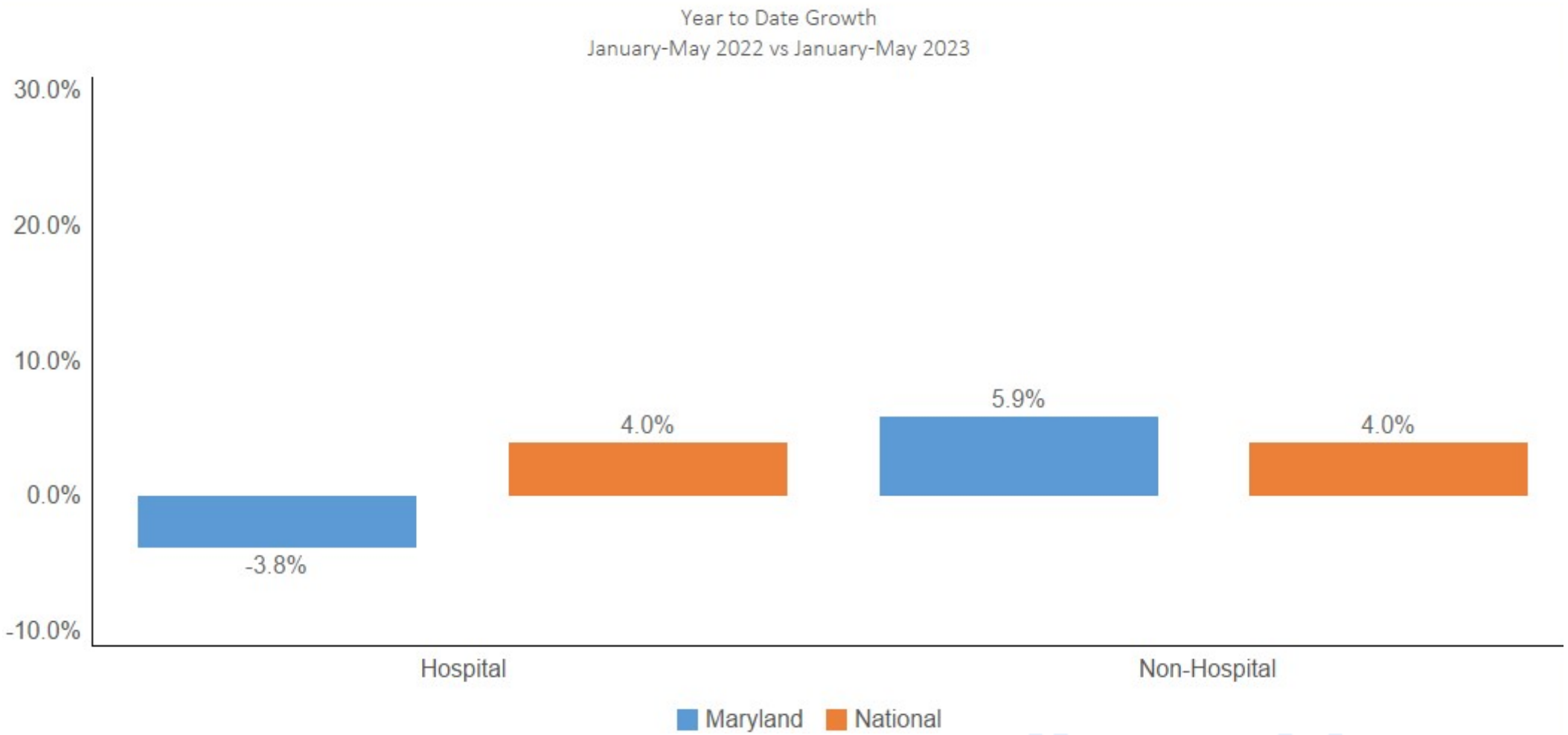
CY16 has been adjusted for the undercharge.

Medicare Non-Hospital Spending per Capita

Actual Growth Trend (CY month vs. Prior CY month)

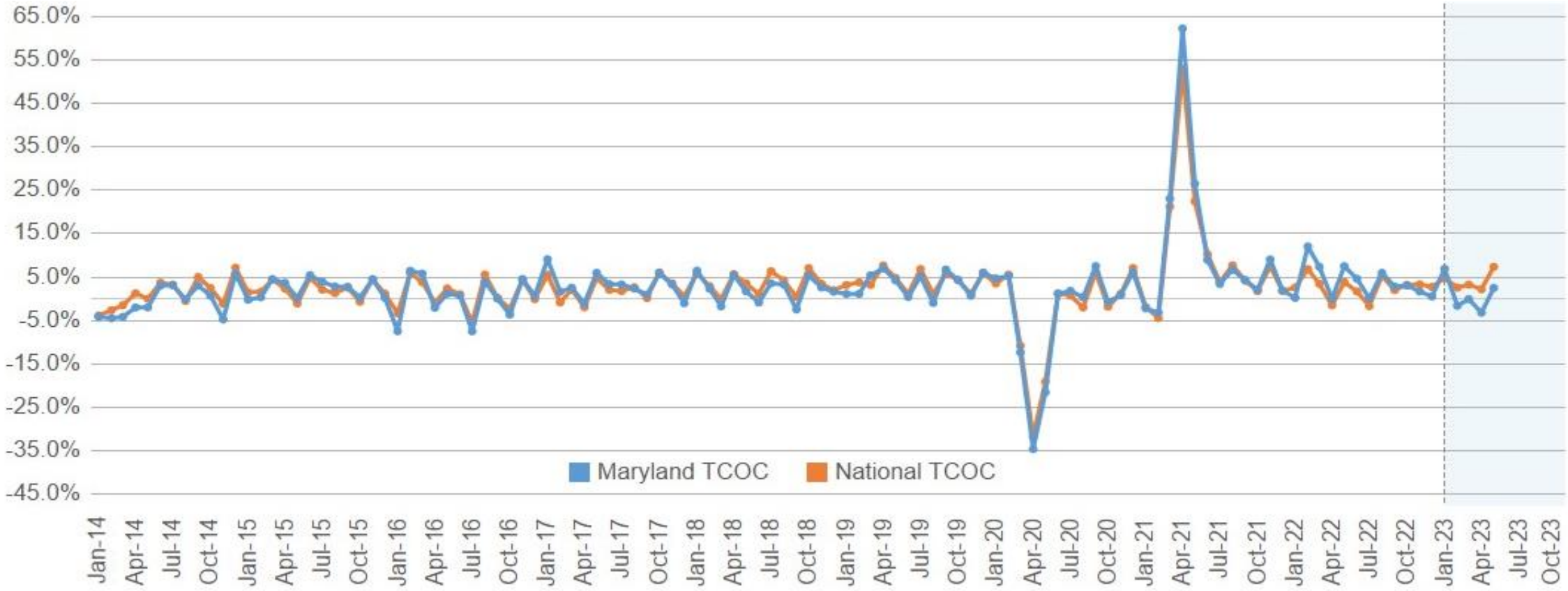


Medicare Hospital and Non-Hospital Payments per Capita



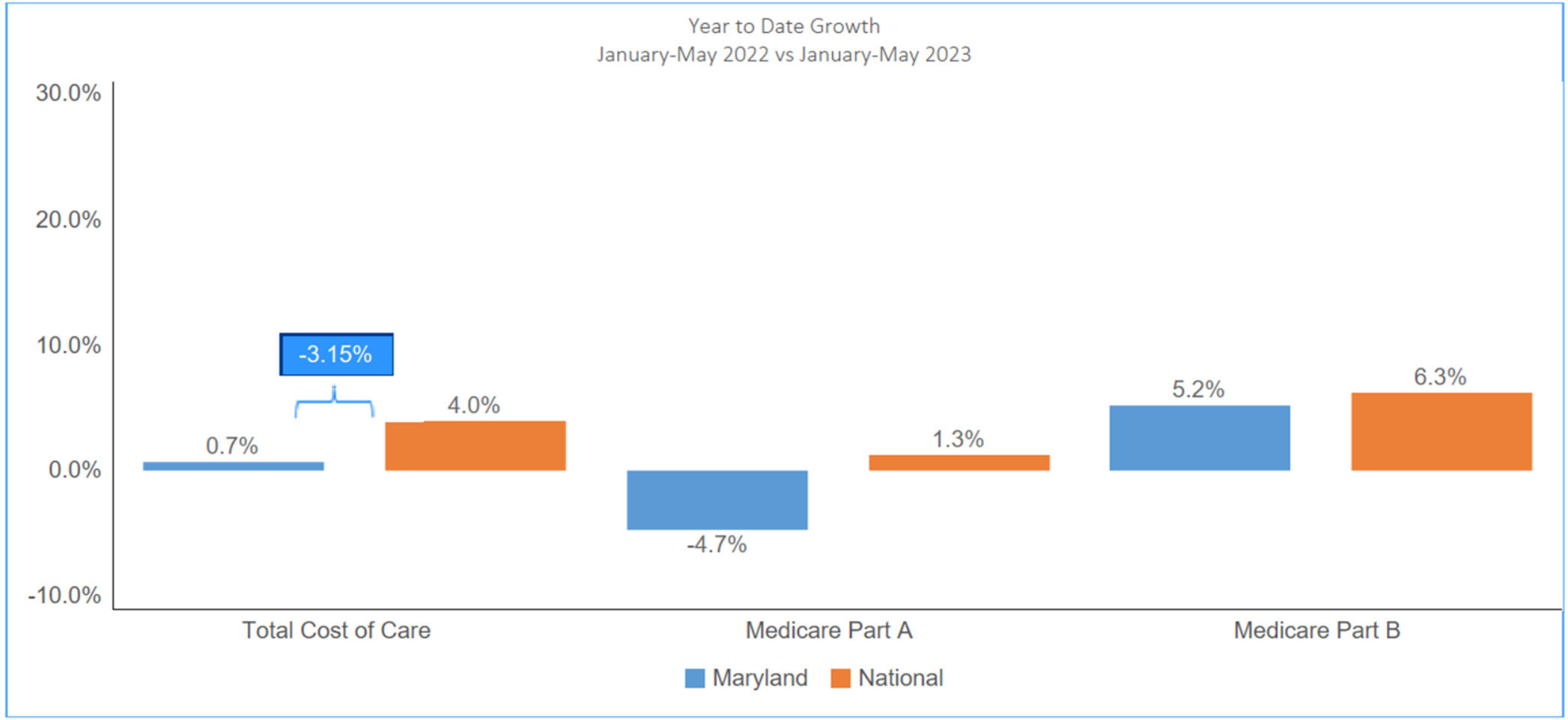
Medicare Total Cost of Care Spending per Capita

Actual Growth Trend (CY month vs. Prior CY month)

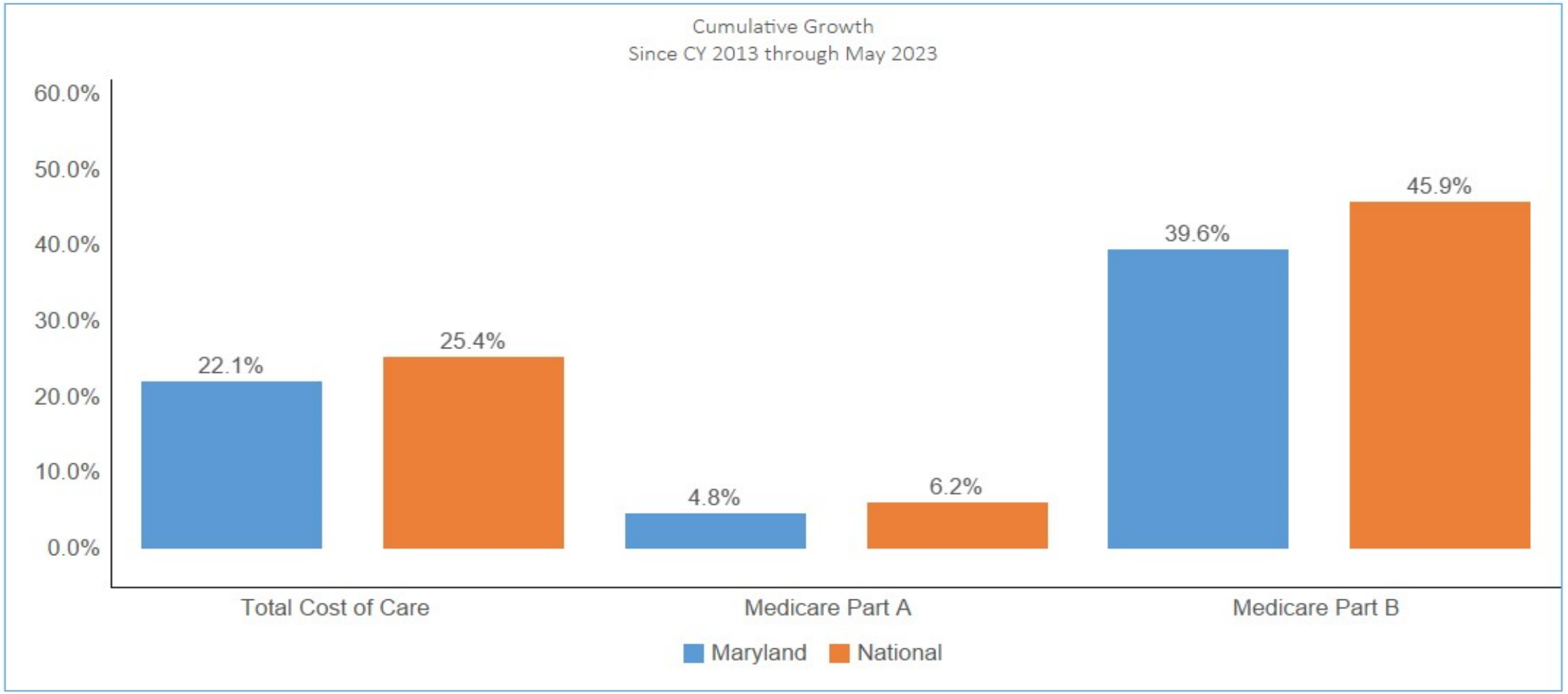


CY16 has been adjusted for the undercharge

Medicare Total Cost of Care Payments per Capita

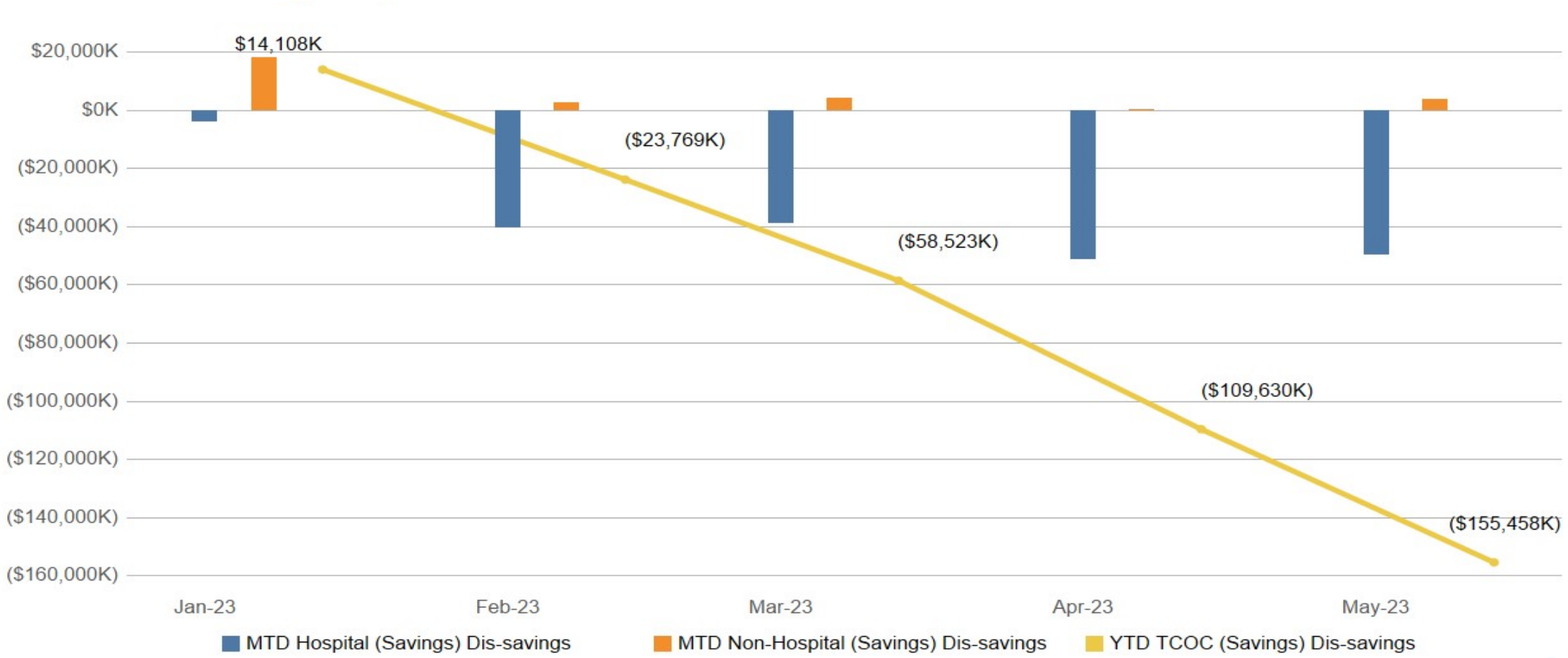


Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through May 2023



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Emergency Department Dramatic Improvement Effort (EDDIE)

September Commission Meeting

Geoff Dougherty and Alyson Schuster

EDDIE Overview

- Maryland has underperformed most other states on ED throughput measures since before the start of the All-Payer model
- EDDIE is a Commission-developed quality improvement initiative with two components:

EDDIE: Improved ED Experience for Patients

Quality Improvement

- Rapid cycle QI initiatives to meet hospital set goals related to ED wait times
- Learning collaborative
- Convened by MHA

Commission Reporting

- Public reporting of monthly data for three measures
- Led by HSCRC and MIEMSS

MHA Quality Improvement Initiative: Example of Hospital Goals

Meritus Health will reduce ED arrival to discharge home from median 219 minutes in FY23 to 209 minutes (median) from July 1, 2023 to December 31, 2023.

Commission requests that hospitals submit short term, specific, and measurable goals related to ED throughput to MHA for reporting at October Commission meeting

Luminis Health Anne Arundel Medical Center will reduce ED arrival to discharge home (OP-18a measure) from FY23 median of 258 minutes to median of 245 minutes for the timeframe July 1, 2023 to December 31, 2023.

Luminis Health Doctor's Community Medical Center will reduce ED arrival to discharge home (OP18a measure) from FY23 median of 289 minutes to median of 275 minutes for the timeframe July 1, 2023 to December 31, 2023.

August 2023 Reporting

Monthly, public reporting of three measures:

- ED1 Inpatient arrival to admission time
- OP18 Outpatient ED arrival to discharge time
- EMS turnaround time (data from MIEMSS)

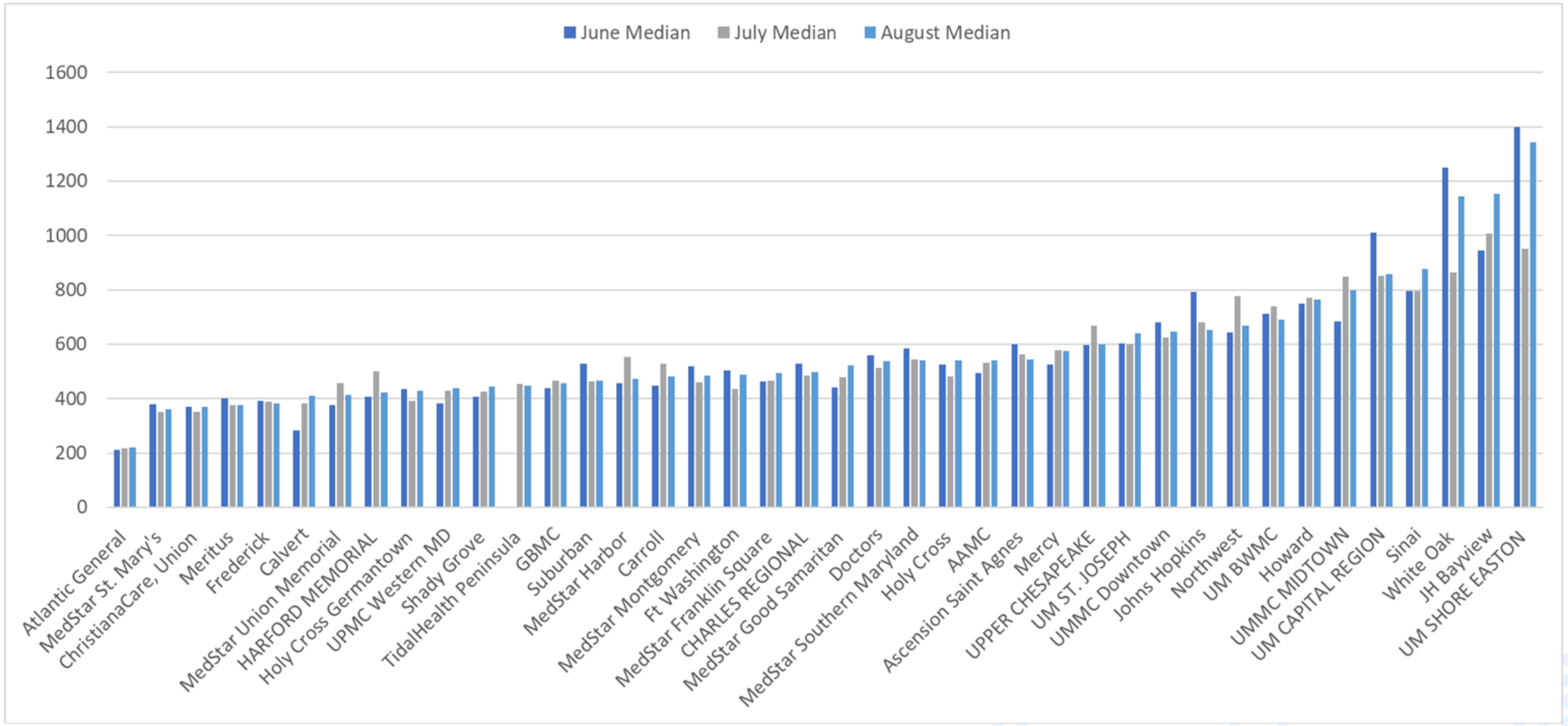
Reports received for all hospitals in August

- This data may be preliminary and some hospitals have resubmitted previous months as they work through the process of providing the metrics shortly after end of the month
- Garrett reported alternative metrics but is actively working to report requested metrics

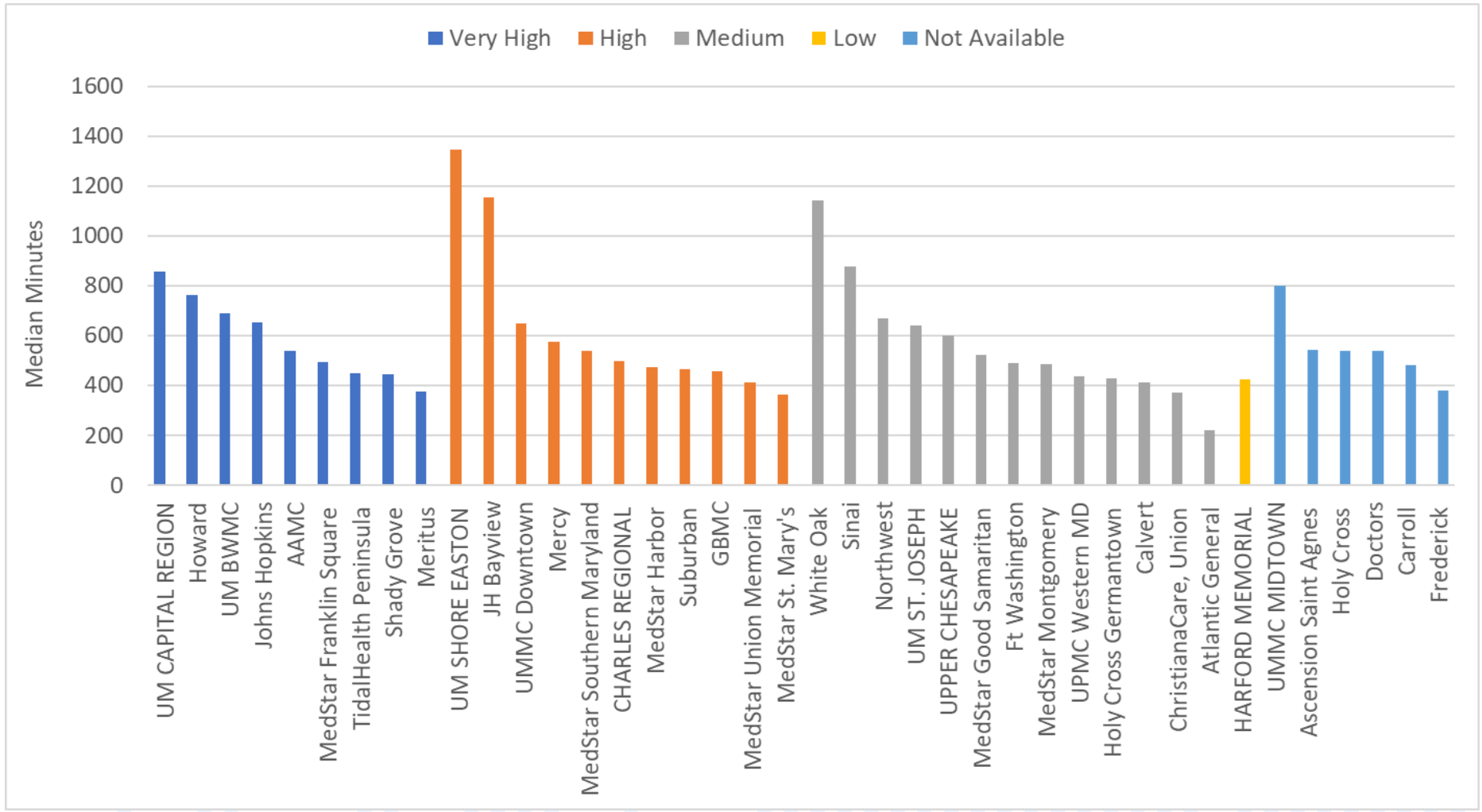
Graphs for ED1a,b,c and OP18a,b,c:

- Month of August and rolling 12 months
- Months of June, July, August
- Month of August grouped by CMS ED volume category (volume data is from CMS Care Compare)

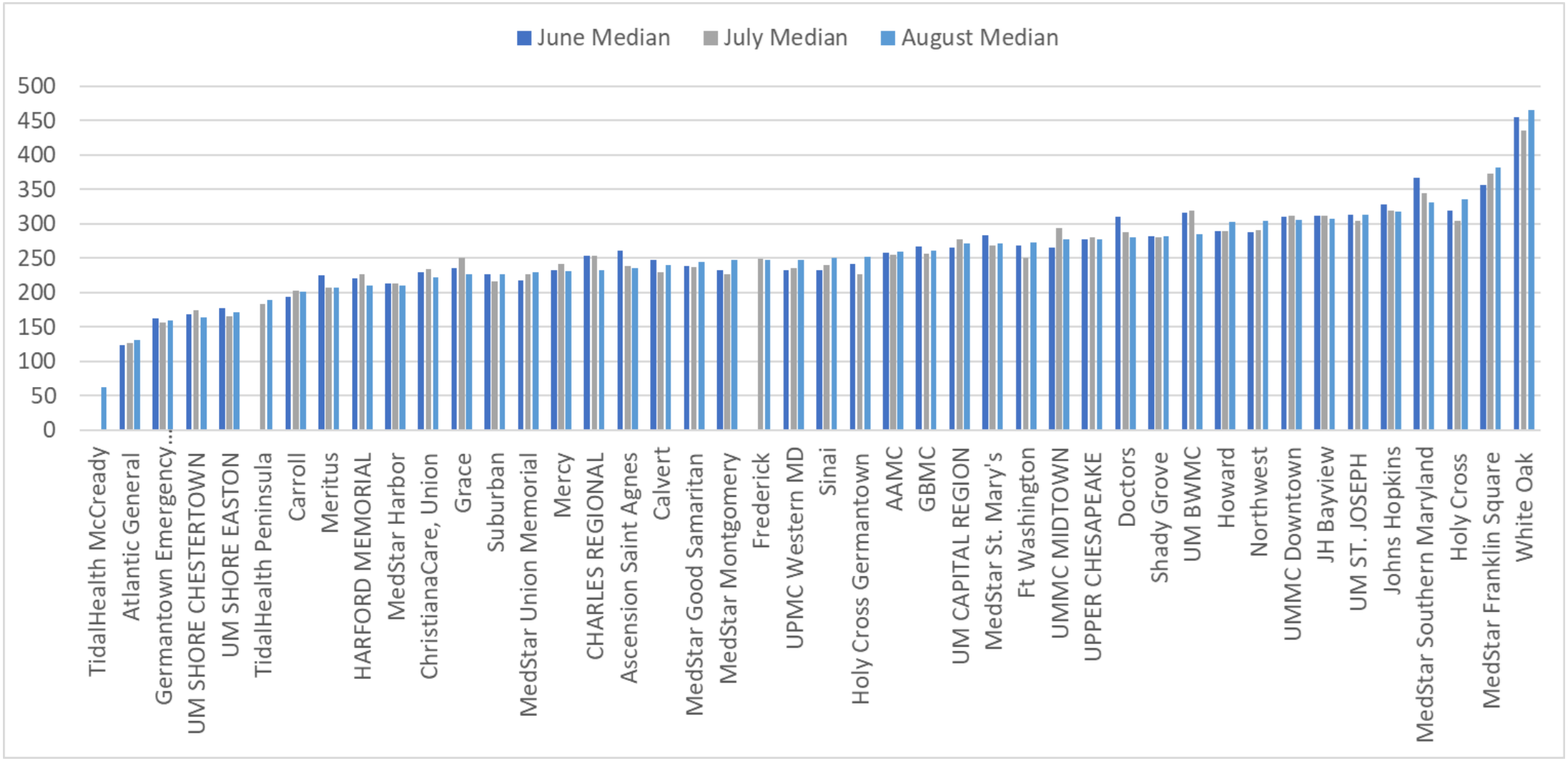
ED 1a: ED Arrival to Inpatient Admission Time by Month



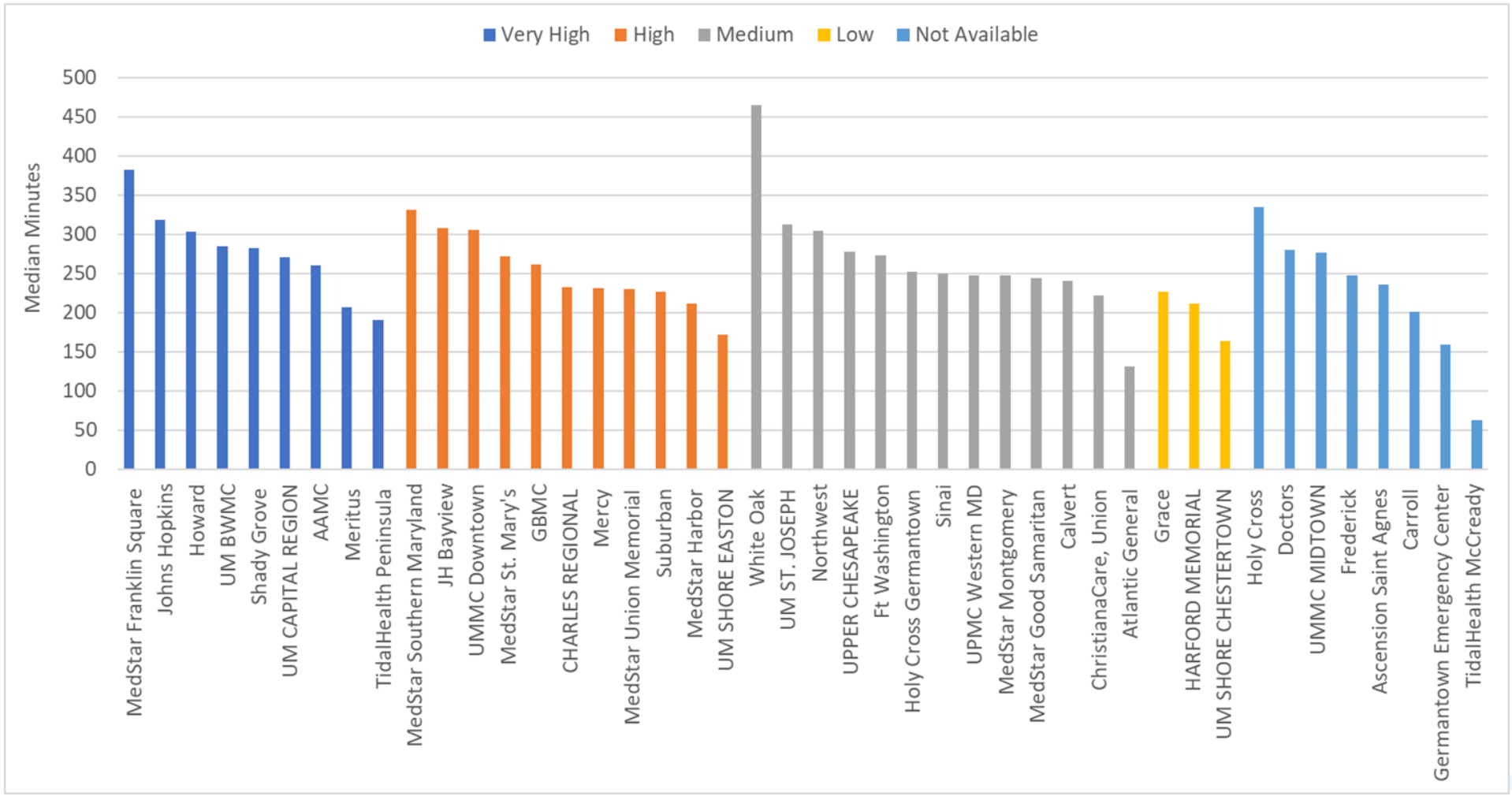
ED 1a: ED Arrival to Inpatient Admission Time August Median By Volume



OP18a: ED Arrival to Discharge Time by Month



OP18a: ED Arrival to Discharge Time August Median By Volume



EMS Turnaround: Time (Minutes) at 90th Percentile

Facilities	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
McCready Health Pavilion	6.8	6.8	12.5	8.8	6.5	7.1	5.8	4.7
Atlantic General Hospital	8.8	8.0	9.0	8.3	9.2	10.0	10.6	10.2
Western Maryland (UPMC)	14.0	14.0	13.0	15.0	15.0	15.0	13.2	11.9
Garrett Regional Medical Center (WVU)	14.0	12.9	15.0	12.6	13.3	13.7	12.8	12.7
Meritus Medical Center	16.9	16.6	14.7	15.8	16.2	16.7	15.0	16.9
Peninsula Regional (TidalHealth)	18.7	18.3	17.7	17.1	18.4	18.6	17.0	17.0
Walter Reed National Military Medical Center	26.8	26.8	17.3	21.1	32.0	17.2	24.0	17.4
Harford Memorial Hospital	24.3	21.2	28.0	25.6	21.5	22.0	21.0	18.2
Frederick Health Hospital	23.6	22.2	20.0	18.6	20.6	21.0	20.1	20.0
Cambridge Free-Standing ED (UMSRH)	31.0	24.0	17.5	25.6	21.0	22.5	19.0	20.4
Germantown Emergency Center (Adventist)	25.0	25.7	24.1	26.6	21.8	20.7	19.9	20.7
Union Hospital (ChristianaCare)	25.0	24.7	22.4	23.3	21.2	25.0	25.0	23.0

Source: MIEMSS

EMS Turnaround: 0-35 Minutes, continued

Facilities	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
R Adams Cowley Shock Trauma Center	35.0	36.9	35.7	37.1	30.8	25.5	23.6	23.3
Kimbrough Ambulatory Care Center								23.4
Holy Cross Germantown Hospital	31.3	27.7	27.5	28.3	28.8	26.9	28.1	23.9
Johns Hopkins Hospital PEDIATRIC	29.1	30.8	34.0	32.1	31.0	25.4	31.4	24.0
Queenstown Emergency Center (UMSRH)	36.8	21.5	24.0	26.5	17.3	25.4	24.7	27.0
St. Mary's Hospital (MedStar)	35.6	33.6	30.0	28.0	31.7	35.2	33.0	28.4
Union Memorial Hospital (MedStar)	37.6	34.5	33.0	33.0	32.6	30.0	30.0	29.2
Montgomery Medical Center (MedStar)	36.0	34.1	35.1	29.8	31.7	32.2	32.5	31.0
Shady Grove Medical Center (Adventist)	40.9	34.5	33.7	33.8	32.0	37.5	35.1	32.3
Carroll Hospital Center (LifeBridge)	46.9	42.7	41.1	35.5	37.1	32.2	35.4	33.0
Grace Medical Center (LifeBridge)	54.0	44.0	41.8	41.6	33.0	36.6	37.0	34.6
Good Samaritan Hospital (MedStar)	51.8	42.5	37.7	35.6	38.7	33.1	34.4	34.8
St. Joseph Medical Center (UM)	54.3	40.0	33.3	31.6	34.7	36.0	36.8	34.9

EMS Turnaround: 35 to 60 minutes

Facilities	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Greater Baltimore Medical Center	61.5	49.4	46.0	40.8	39.5	40.4	36.5	35.7
Franklin Square (MedStar)	50.5	42.5	38.3	33.8	36.3	34.7	35.3	37.8
Holy Cross Hospital	52.6	49.8	45.5	44.0	46.5	47.2	42.7	37.9
CalvertHealth Medical Center	38.1	35.7	32.7	37.4	33.6	35.9	40.3	39.6
Easton (UMSRH)	45.0	35.0	39.3	37.5	30.4	42.5	33.8	40.5
Johns Hopkins Bayview	55.5	50.5	43.3	45.0	41.1	42.5	43.6	40.6
Northwest Hospital (LifeBridge)	69.4	50.4	46.4	42.0	41.5	41.4	44.8	40.7
Upper Chesapeake Medical Center (UMUCH)	50.2	44.7	50.2	48.7	45.9	46.7	47.8	40.9
University of Maryland Medical Center	60.0	57.3	55.0	53.8	43.2	40.3	41.4	41.1
Sinai Hospital (LifeBridge)	55.0	47.8	47.1	47.3	44.7	43.1	43.2	43.0
Suburban Hospital (JHM)	44.2	43.0	41.8	38.6	36.9	50.8	43.1	43.6

EMS Turnaround: 35 to 60 minutes

Facilities	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Mercy Medical Center	60.0	50.5	43.7	48.8	46.3	45.0	48.1	44.4
Chestertown (UMSRH)	38.6	46.1	41.2	36.7	36.8	38.4	46.6	44.4
Johns Hopkins Hospital ADULT	52.4	52.6	50.0	49.6	44.1	46.0	46.0	46.1
Charles Regional (UM)	93.5	64.7	54.3	51.6	81.7	85.4	64.5	47.9
Bowie Health Center (UMCRH)	68.8	64.7	68.5	60.9	50.3	72.2	51.4	48.6
Harbor Hospital (MedStar)	79.5	59.7	60.0	62.5	65.7	54.0	55.0	49.9
St. Agnes Hospital (Ascension)	66.8	60.3	60.3	58.4	54.8	53.3	47.7	52.5
Midtown (UM)	66.7	64.8	56.1	56.8	50.0	52.8	51.3	53.0
Laurel Medical Center (UMCRH)	85.0	82.5	73.0	62.3	62.9	70.7	68.4	59.8

EMS Turnaround: Greater than 60 minutes

Facilities	Jan	Feb	Mar	Apr	May	Jun
Anne Arundel Medical Center	78.3	67.4	80.4	74.6	78.7	70.8
Bowie Health Center (UM)	68.8	64.7	68.5	60.9	50.3	67.4
Capital Region Medical Center (U)	113.2	105.8	90.2	106.0	95.9	102.4
Charles Regional (UM)	93.5	64.7	54.3	52.0	81.7	85.6
Doctors Community Medical Center (Luminis)	94.3	90.5	74.9	82.5	92.4	91.3
Fort Washington Medical Center (Adventist)	124.3	120.4	96.2	91.6	90.5	83.9
Howard County General Hospital (JHM)	69.4	58.9	56.7	60.9	64.5	68.4
Laurel Medical Center (UM)	85.0	82.5	73.0	62.3	62.9	69.1
Southern Maryland Hospital (MedStar)	109.2	114.4	97.6	91.9	90.4	94.7

EMS Turnaround: Greater than 60 minutes

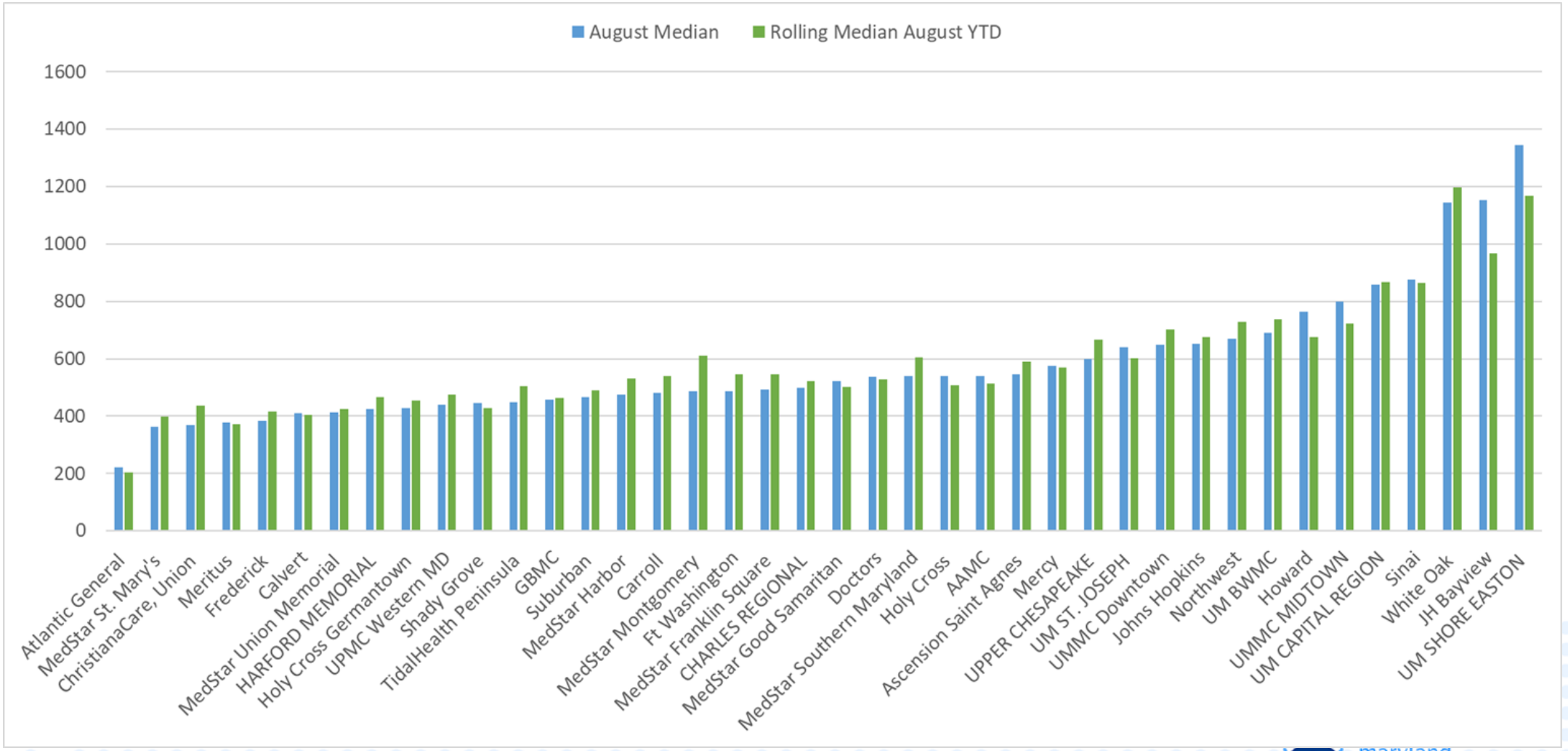
Facilities	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Baltimore Washington Medical Center	81.5	63.7	68.9	74.1	67.1	61.4	65.9	61.6
Howard County General Hospital (JHM)	69.4	58.9	56.7	60.9	64.6	69.0	67.6	64.4
Anne Arundel Medical Center	78.3	67.4	80.4	74.6	78.7	71.0	70.5	68.0
Southern Maryland Hospital (MedStar)	109.2	114.4	97.6	91.9	90.4	95.0	91.4	73.3
Doctors Community Medical Center (Luminis)	94.3	90.4	74.9	82.5	92.4	91.6	85.2	81.5
White Oak Medical Center (Adventist)	63.4	51.0	52.6	52.3	54.4	57.6	64.6	87.7
Capital Region Medical Center (UMCRH)	113.2	105.8	90.2	106.0	95.8	101.5	100.8	92.9
Fort Washington Medical Center (Adventist)	124.3	120.4	96.2	91.6	90.5	84.8	79.0	97.2

Next Steps

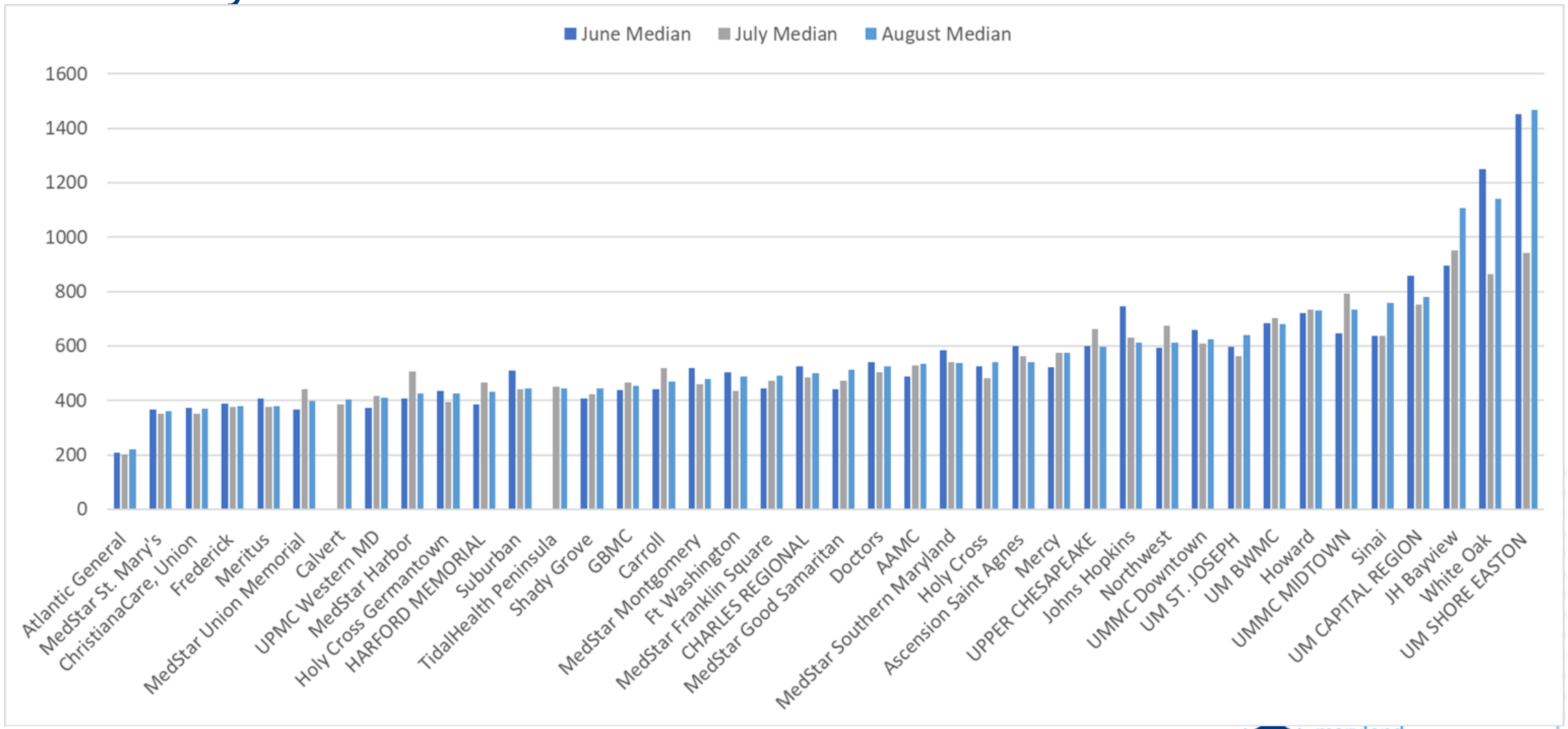
- Continue monthly data collection from hospitals and MIEMSS
  - Address reporting questions and concerns with hospitals
  - Present results at monthly Commission meeting
  - Add visualizations suggested by Commissioners and other stakeholders
- Collect and present **all** hospital improvement goals collected by MHA at October Commission meeting
  - Goals should be short term, specific, and measurable
- Collaborate with MHA on legislative request and EDDIE quality improvement initiative

Appendix

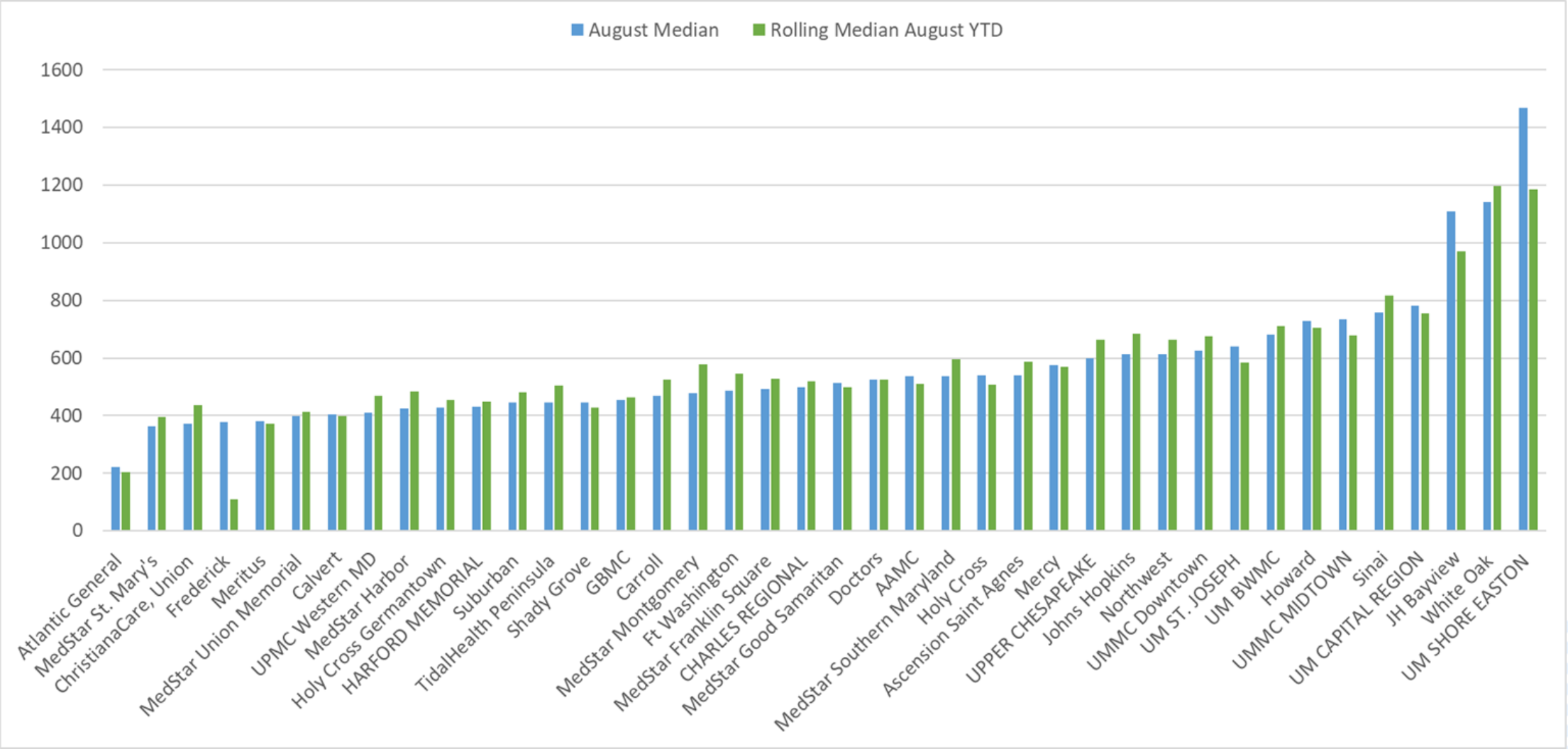
ED 1a: ED Arrival to Inpatient Admission Time - Monthly and Rolling 12-Months



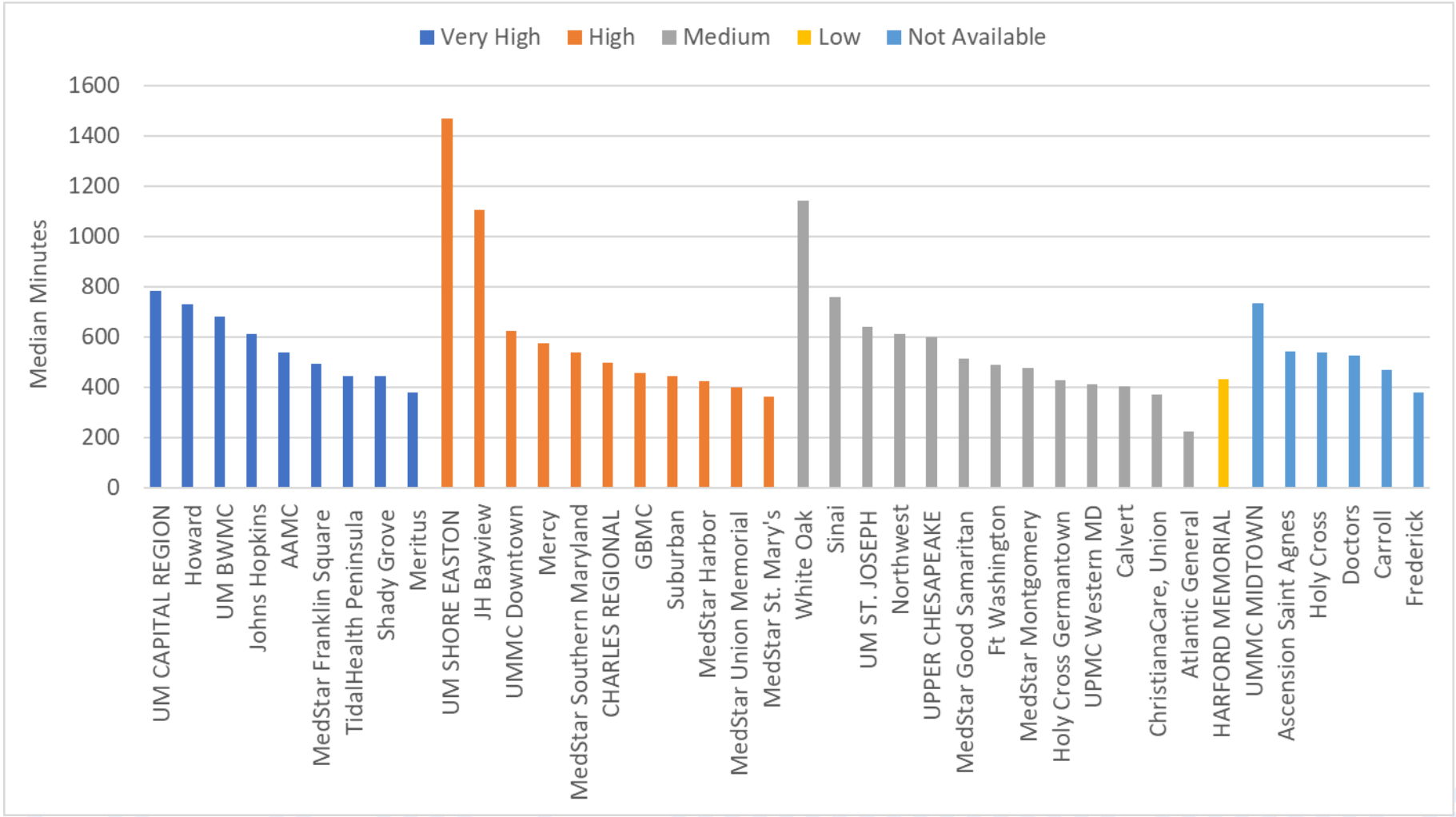
ED 1b: ED Arrival to Inpatient Admission Time by Month Non-Psychiatric ED Visits



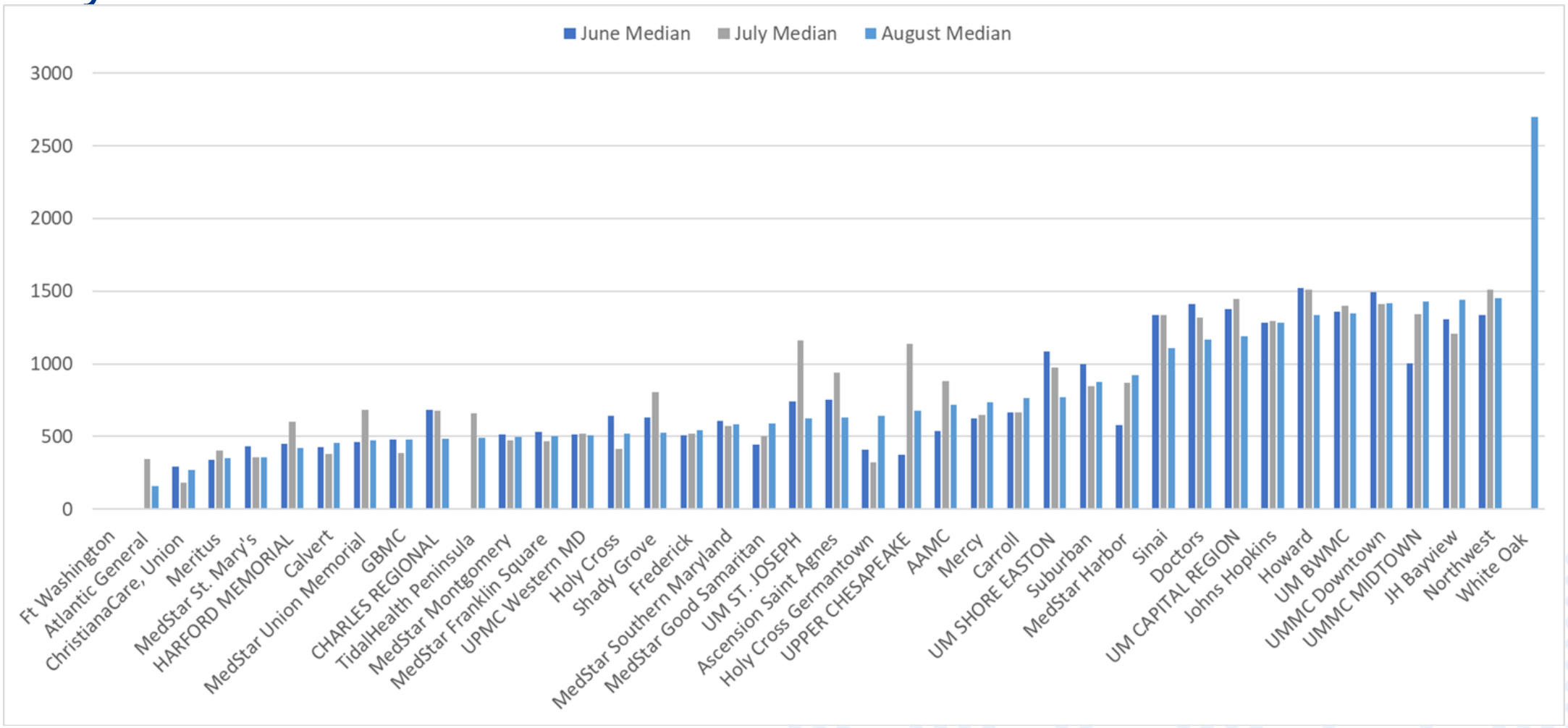
ED 1b: ED Arrival to Inpatient Admission Time - Monthly and Rolling 12-Months: Non-Psychiatric ED Visits



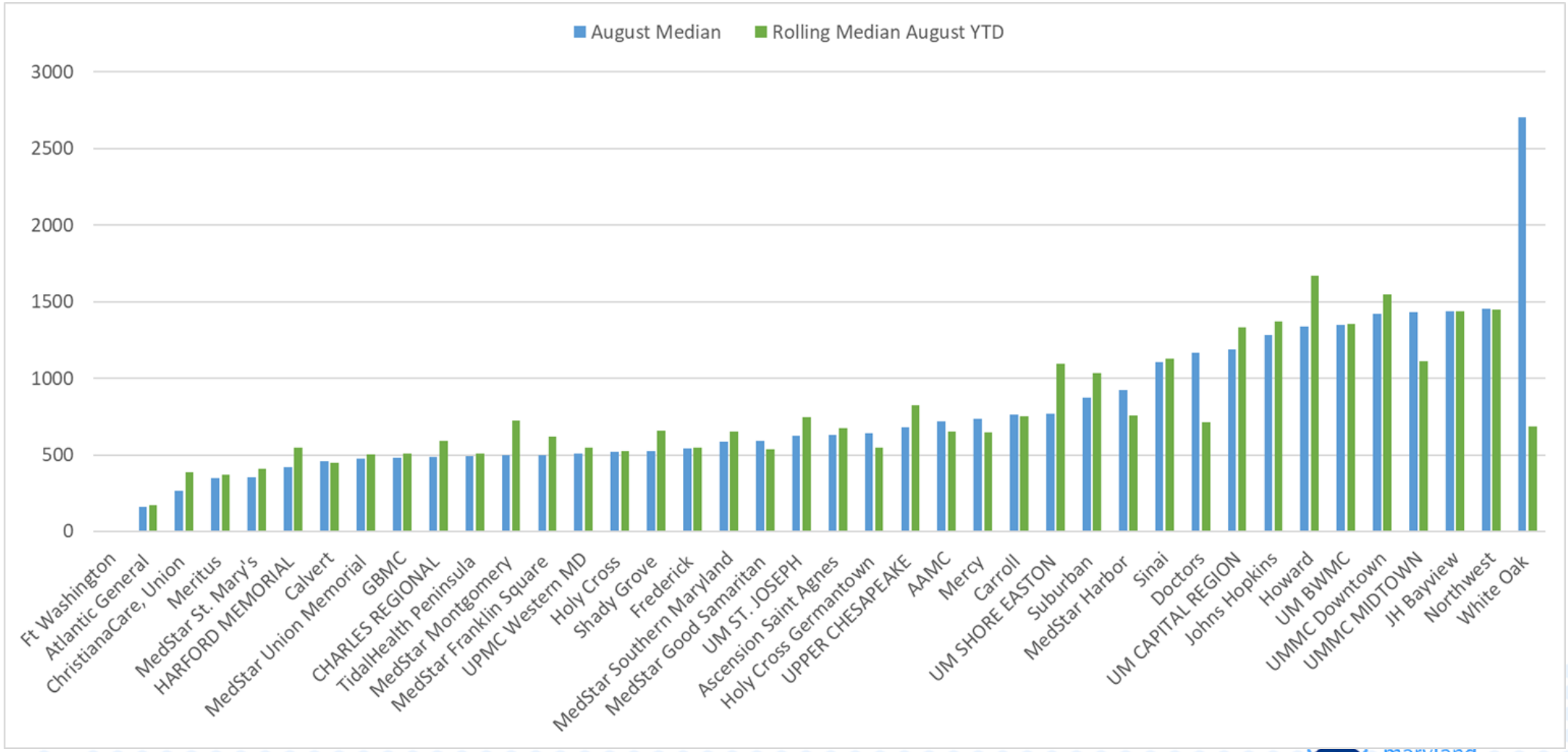
ED 1b: ED Arrival to Inpatient Admission Time by Volume Non-Psychiatric ED Visits



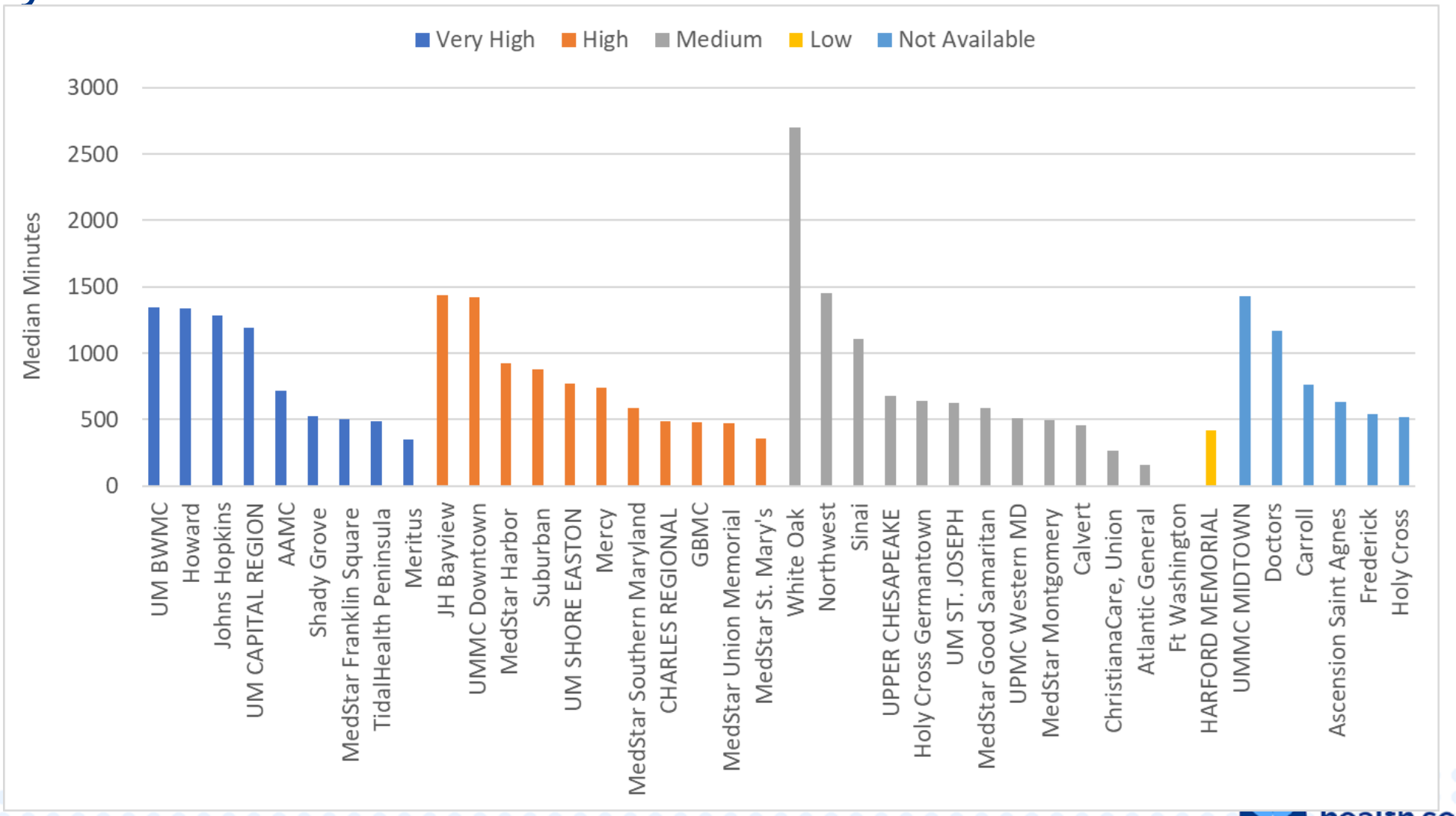
ED 1c: ED Arrival to Inpatient Admission Time by Month Psychiatric ED Visits



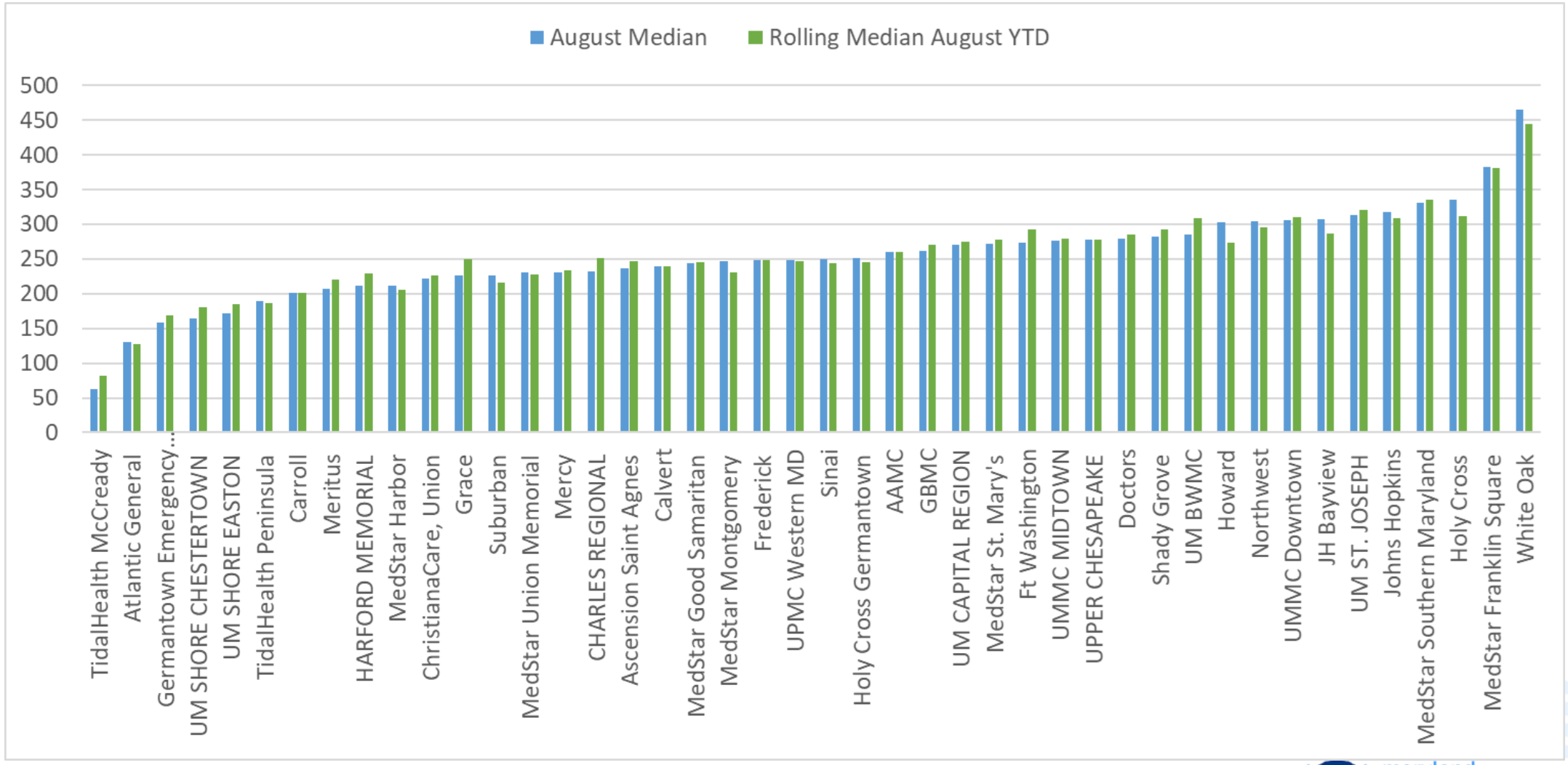
ED 1c: ED Arrival to Inpatient Admission Time - Monthly and Rolling 12-Months: Psychiatric ED Visits



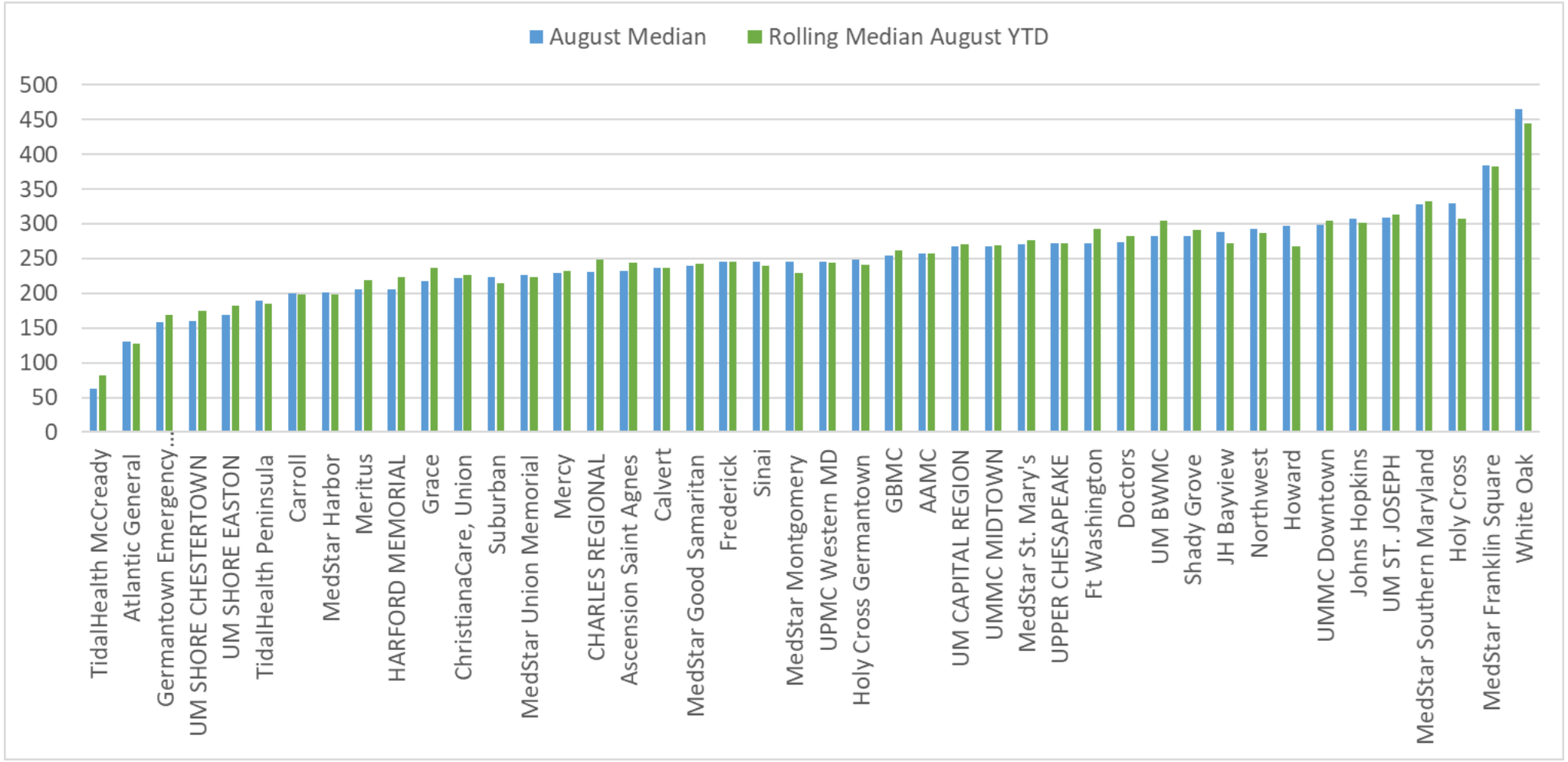
ED 1c: ED Arrival to Inpatient Admission Time by Volume Psychiatric ED Visits



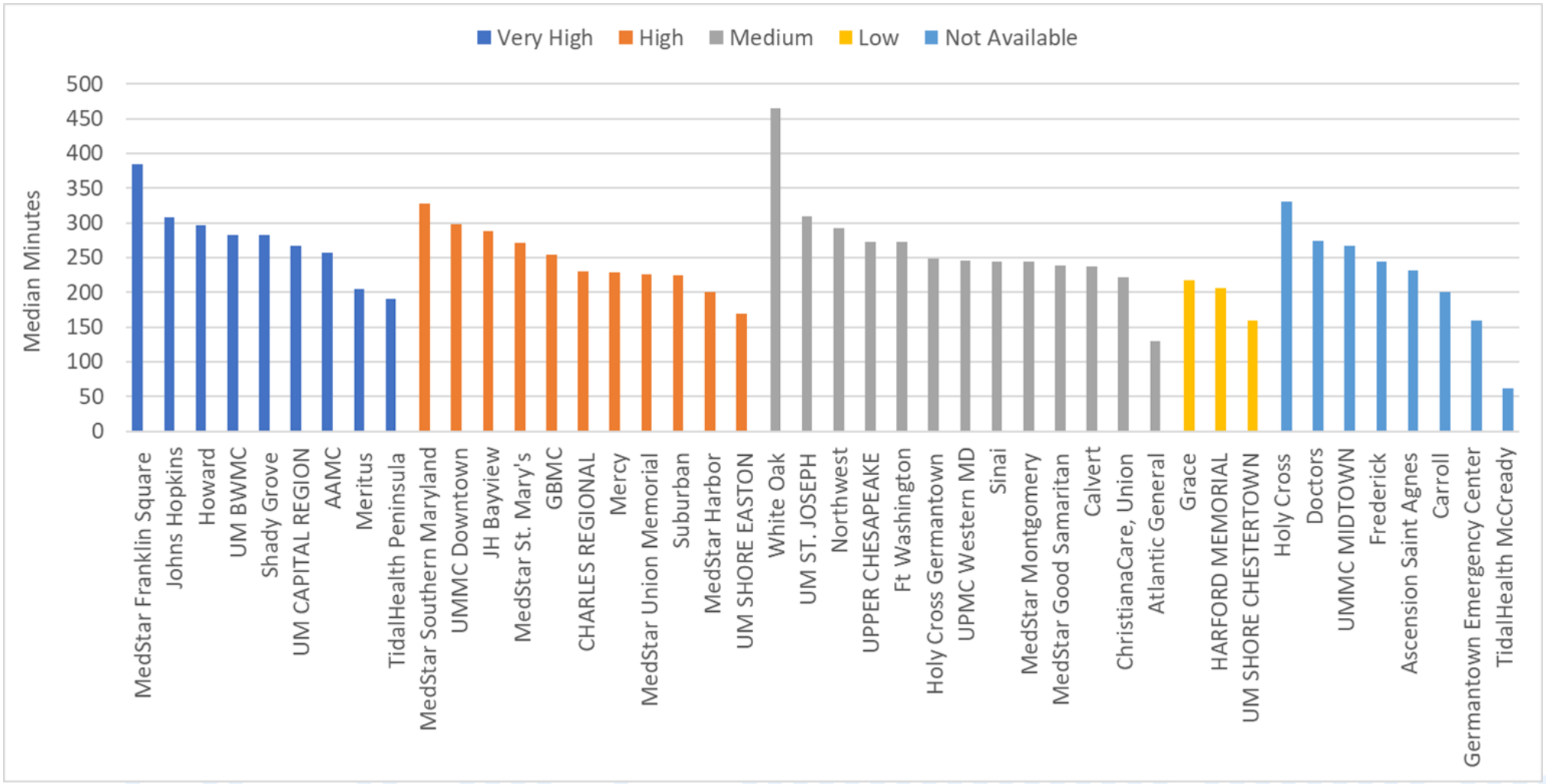
OP18a: ED Arrival to Discharge Time - Monthly and Rolling 12-Months



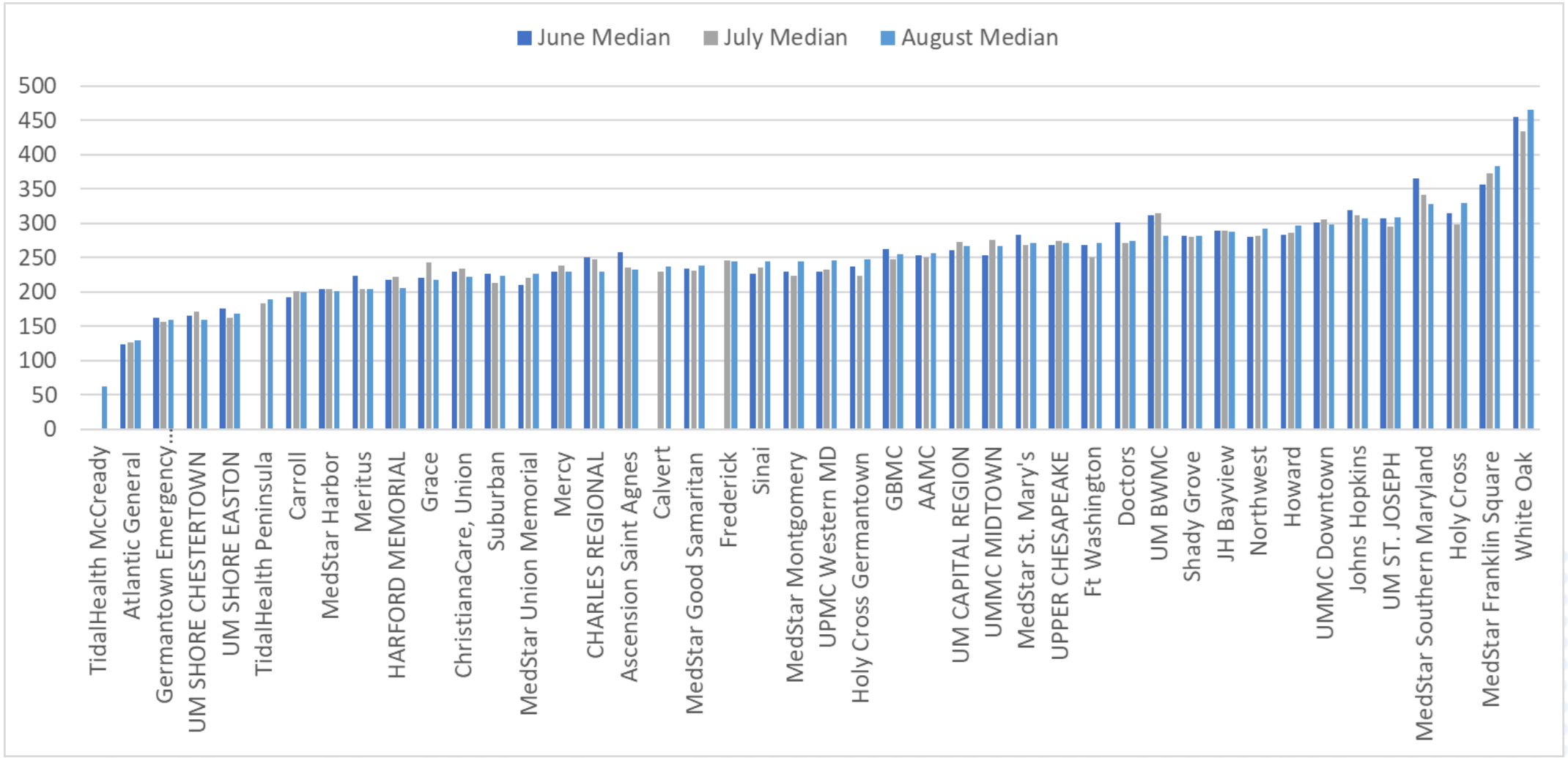
OP18b: ED Arrival to Discharge Time - Monthly and Rolling 12-Months: Non-Psychiatric ED Visits



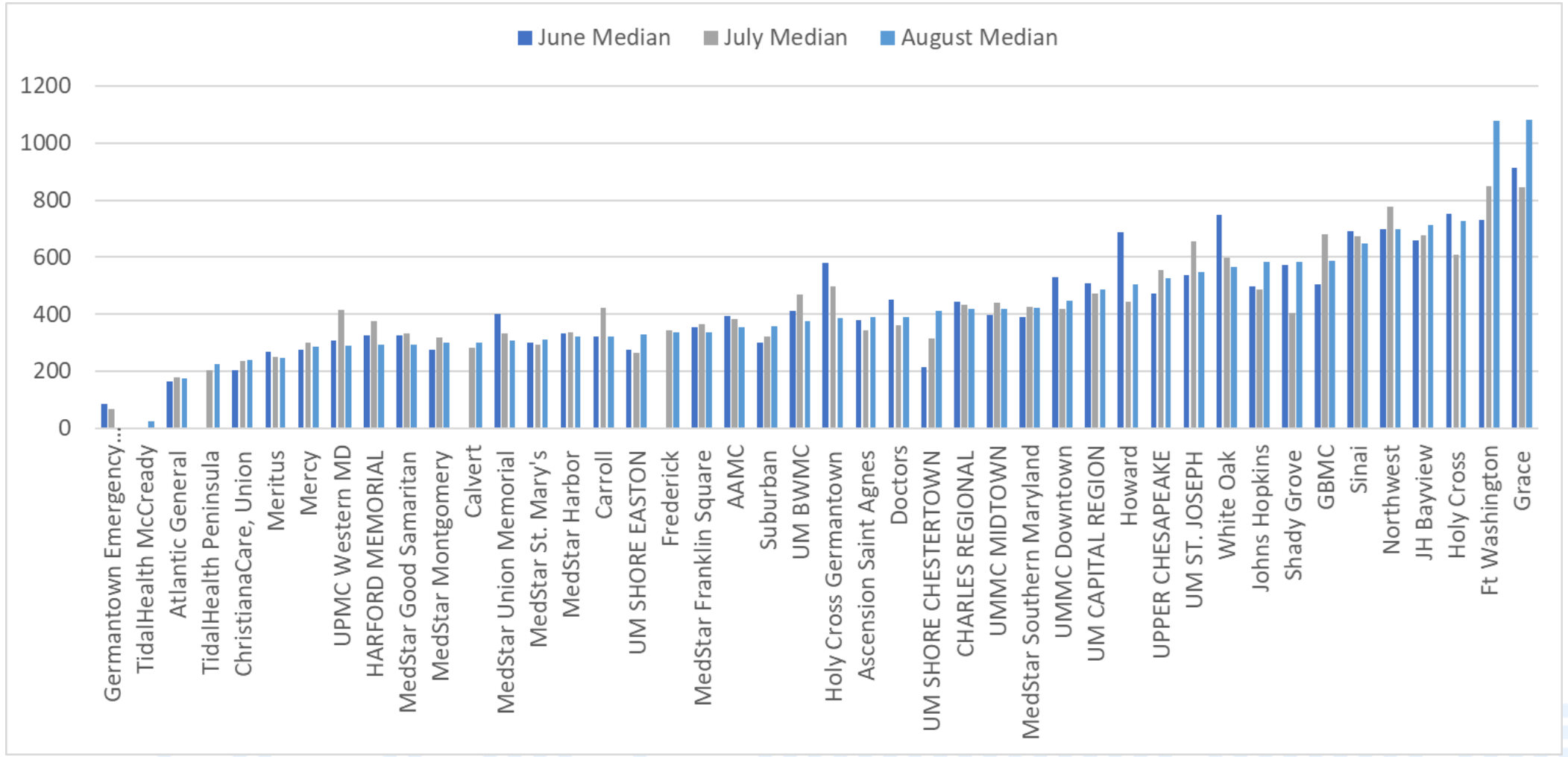
OP18b: ED Arrival to Discharge Time by Volume Non-Psychiatric ED Visits



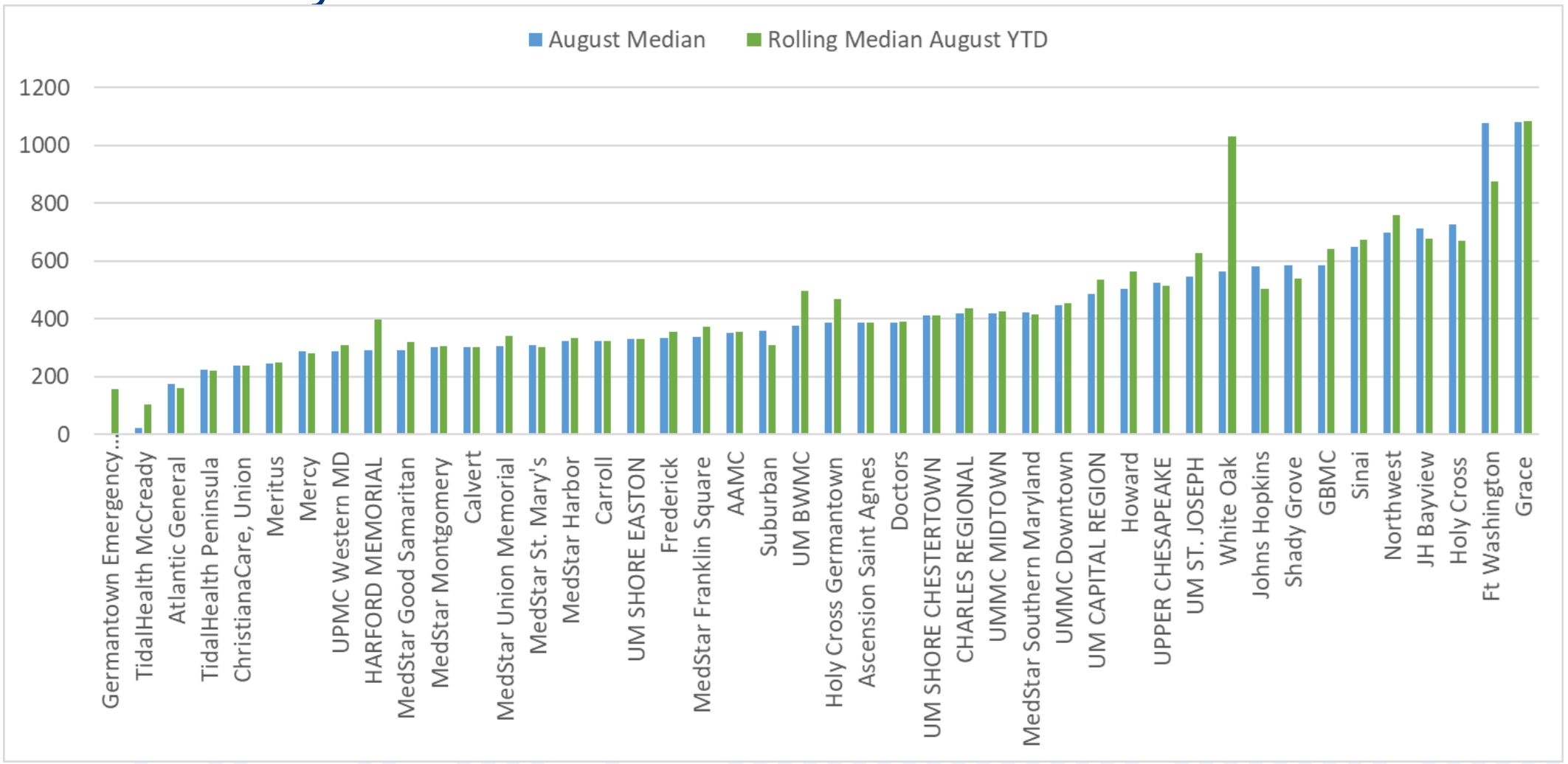
OP18b: ED Arrival to Discharge Time by Month Non-Psychiatric ED Visits



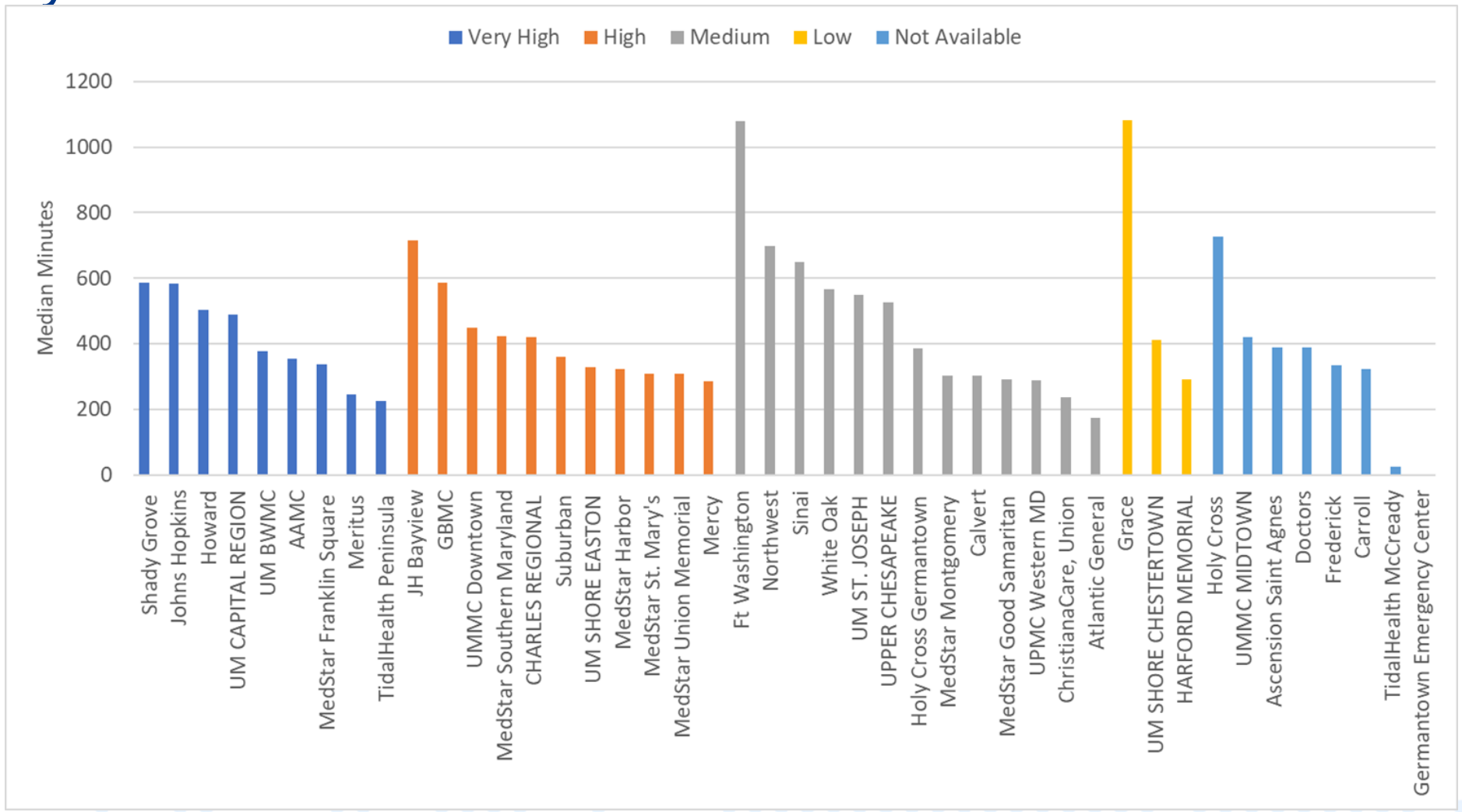
OP18 c: ED Arrival to Discharge Time by Month Psychiatric ED Visits



OP18 c: ED Arrival to Discharge Time - Monthly and Rolling 12-Months: Psychiatric ED Visits



OP18 c: ED Arrival to Discharge Time by Volume Psychiatric ED Visits



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Revenue for Reform Criteria

Revenue for Reform Overview

Core Objective:

Hospitals are key drivers of community health improvement in their communities. Revenue for Reform (R4R) provides the opportunity for hospitals facing reductions in their Annual Update Factor under the Integrated Efficiency policy to make population health investments in place of their efficiency cut. The parameters for approving qualified population health investments ensure that R4R initiatives are aligned with statewide population health efforts, evidence-based, and accountable for delivering population health impact.

Policy Overview:

- Through the Integrated Efficiency Policy, hospitals that significantly reduce volume are subject to an inflationary reduction because of the reduced variable costs associated with the drop in volume. However, within the TCOC Model, retained revenue should be reinvested toward population health.
- R4R allows these hospitals to offset reductions in the Annual Update Factor with approved population health investments. For example:
    - If the hospital would have received a $10 million dollar reduction in its Annual Update Factor because of having inflation withheld but had spent $7 million in qualified population health spending, then the hospital would receive an efficiency cut of only $3 million ($10 million efficiency adjustment - $7 million in a qualifying population health safe harbor).

Revenue for Reform Overview

R4R requirements as approved in July:

- Population health investments must meet certain criteria to qualify for R4R. To qualify, investments:
  - Must be made outside the hospital;
  - Must be for non-physician costs except primary care (as defined by the Maryland Primary Care Program), mental health, or dental providers costs;
  - Must principally serve the people in the hospital's primary service area;
  - Must be related to an unmet need identified in a CHNA, CDC's Healthy People 2030, or other population health planning document identified by MDH (e.g., the SHIP);
  - Must be evidence-based; and
  - May leverage a Regional Partnership.
- R4R proposals must also be approved MDH.

Revenue for Reform Update

MDH approval criteria and processes:

- MDH and HSCRC staff are developing a process for:
  - Submitting and reviewing proposals
  - Establishing a framework for measuring population health impact and tracking key performance indicators.
  - Working with hospitals to revise/refine proposals that do not align with approval criteria, and
  - Rejecting proposals that can not meet approval criteria after revision.
- For future years, MDH (with support from HSCRC staff) is working to clearly define additional criteria for approval of R4R proposals. The criteria will:
  - Identify key, statewide priorities for population health and community health investment.
  - Establish a framework for measuring population health impact and tracking key performance indicators.
  - Outline a process for repurposing R4R investments if the intervention no longer aligns with statewide priorities and/or proves to be unsuccessful
- Proposed criteria and processes will be reviewed with Commissioners and stakeholders for feedback and comment.

Revenue for Reform Update

Additional R4R processes:

- HSCRC staff have drafted an initial proposal template that will be reviewed by MDH and then released to hospitals with opportunity for R4R investment in October.
  - Proposals tentatively due in December
  - Initial proposals approved in January
- MDH and HSCRC will also begin to schedule preliminary meetings with hospitals with opportunity for R4R investment to understand current population health investments and discuss potential R4R proposals for 2023/2024.

Revenue for Reform Update

Additional R4R processes:

- MDH and HSCRC will partner to provide technical assistance as needed for hospitals developing R4R proposals.
- MDH and HSCRC will develop process for reviewing R4R investment progress on an annual and continuing basis and redirecting investments that are not meeting proposed metrics.
  - Proposed review process will be presented to Commissioners and stakeholders for feedback.

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TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: September 13, 2023

RE: Hearing and Meeting Schedule

October 11, 2023 To be determined - GoTo Webinar

November 8, 2023 To be determined - GoTo Webinar

The Agenda for the Executive and Public Sessions will be available for your review on the Wednesday before the Commission meeting on the Commission's website at http://hscrc.maryland.gov/Pages/commission-meetings.aspx.

Post-meeting documents will be available on the Commission's website following the Commission meeting.